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New data reveal the trend in drug-related deaths in Ireland over a 23-year period.

(Report on page 20)

Drugs and crime in Ireland

The illicit drug market and associated crime have a corrosive impact on Irish public life and society – whether in terms of the high-profile killing of rivals in the internecine world of Dublin drug gangs, the fear and intimidation of the impoverished communities within which they mostly ply their trade or the petty thefts and robberies committed by drug users to support their addiction. Because of the huge profits which can be derived from the illicit drug market and the increasing public demand for illicit substances, initiatives aimed at deterring criminal organisations or individual criminals from involvement in drug trafficking face major challenges. Drug law enforcement activities may have contributed to the relative containment of illicit drug use and the authorities have had some success in disrupting drug markets and dismantling organised crime groups. However, there is little evidence in Ireland or internationally that such strategies have halted the expansion of the illicit drug market or reduced the criminal activities surrounding it for any sustained period of time.[1]

(continued on page 2)

Green Paper on the Role of Civil Society in Drugs Policy in the European Union

The European Commission has published a Green Paper on the Role of Civil Society in Drugs Policy in the European Union (COM (2006) 316 Final). The Green Paper explores ways to involve civil society in the planning and implementation of EU drugs policy. Voluntary and community organisations in member states, including Ireland, are invited to give their opinions and experiences.

The Green Paper was developed on foot of a conference held in Brussels in January, attended by over 140 participants representing European NGO networks, including voluntary organisations in 16 member states, four accession and candidate countries, and Norway. This conference explored the options and highlighted issues with regard to the involvement of civil society in the planning and implementation of EU drugs policy.

The Green Paper was published on 26 June, which was International Day against Drug Abuse and Illicit Trafficking, and the consultation period will run until the end of September 2006. The Green Paper and further information regarding the consultation can be found at http://europa.eu

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Drugs and crime in Ireland *(continued)*

Drugs and crime in Ireland,[2] the third title in the Drug Misuse Research Division's Overview series, was published in May 2006. The purpose of this Overview was to compile and analyse existing data and available research on drug offences and drug-related crime, to identify gaps in knowledge and to inform future research needs in this important area of drug policy.

The link between drugs and crime in Ireland exists simply by virtue of prevailing legislation which defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. Offences committed under this legislation are reported in the annual reports of An Garda Síochána. Overview 3 describes and analyses trends in drug offences since 1983. The limitations of official statistics in terms of describing the overall crime picture have been highlighted by a number of writers in this area. These limitations, specifically in relation to drug-related crime, are considered in the Overview.

Although the link between drugs and crime has been firmly established in the public consciousness in Ireland, there has been little sustained examination of the precise nature of this link. Most Irish drug users who receive sentences of imprisonment, for example, are punished, not for drug offences per se, but for offences committed as a consequence of their drug use, such as theft from the person, burglary, larceny or prostitution. Research studies have identified this clear link between some forms of illicit drug use and crime – findings which are consistent throughout criminological literature. Although the link between drug use, addiction and crime has been established by international and Irish research, identifying the precise causative connection between drugs and crime has been a primary preoccupation of many writers in this area. For the purpose of this Overview, the available research evidence is reviewed using four explanatory causal models: the psycho-pharmacological model, which identifies the drugs–crime link as arising as a result of the intoxicating effect of the drugs themselves; the economic-compulsive model, which assumes that drug users need to generate illicit income from crime to support their drug habit; the systemic model, which explains drug-related crime as resulting from activities associated with the illegal drug market; and the common-cause model, which suggests that there is no direct causal link between drugs and crime but that both drug use and offending behaviour are related to other factors, including socio-economic deprivation.

Another area which is considered in Overview 3 is one which is gaining increased attention in Ireland and throughout the European Union – the link between illicit drug use and driving offences.

Among the key findings are:

Drug offences

- Drug possession offences account for most drug offences recorded. In 2004, prosecutions for simple possession made up 69 per cent of the total number of prosecutions, while supply offences accounted for 22 per cent of the total.
- Cannabis-related prosecutions have consistently formed the vast majority of all drug-related offences prosecuted.

Drugs and driving

- The typical profile of the apprehended and tested driver found to be under the influence of drugs is that of a young male, driving in an urban area, with low or zero alcohol level, with a specimen provided between the hours of 6 am and 9 pm and with a presence of cannabinoids.
- The difficulty of producing a reliable roadside sample-testing device remains an issue in this area.

Drugs and crime: psycho-pharmacological links

- With regard to the psycho-pharmacological connection between drug use and violent crime, there is overwhelming evidence from the international literature of a connection between alcohol consumption and violence.
- International evidence of a pharmacological link between illicit drug use and violent crime is inconclusive.

Drugs and economically-motivated crime

- That there is an economic motivation to commit crime to purchase drugs has been supported by Irish research. This manifests itself in an increase in such crimes following

Drugs and crime in Ireland *(continued)*

addiction and the reduction of such crimes following participation in closely supervised and well-resourced drug treatment programmes. A number of studies of imprisoned drug users also highlight such links.

- It has been suggested that a 29 per cent reduction in recorded crime in Ireland between 1995 and 1999 might be partially explained by the increased availability of methadone maintenance programmes throughout the Dublin area during that period.

Drugs and systemic crime

- Local studies have highlighted the association of local drug markets with significant levels of community disturbance and anti-social behaviour.
- The operation of local drug markets can engender significant apprehension and a reluctance among local residents to co-operate with law enforcement initiatives because of fear of reprisal from drug dealers.
- The association of drugs and violent crime with systemic aspects of the drug trade is borne out by the increasing evidence of drug-related gangland murders.

Drug-related crime and gender

- A 1999 study of female drug users working in the sex industry found that they differed from non-drug-using women in the same industry in that their primary motivation was to feed their drug habit. The study also found that such women tended to be younger and to have the least favourable health risk profile of all women working in prostitution.
- A 2001 study of drug-using prison inmates referred to them as 'reluctant criminals', in that they engaged in crimes which they perceived involved the lowest risk of arrest.

Common-cause model

- With regard to the drugs–crime link, studies of drug users have found them typically to be single, aged between 14 and 30, male, urban, often still living in the parental home, from large and often broken families, having left school before the legal minimum age of 16, with high levels of unemployment, with their best ever job being in the lowest socio-economic class, with a high number of criminal convictions and high rates of recidivism, with a history of family members being in prison, and a profile of extreme social disadvantage characterised by being from areas with a high proportion of local authority housing and often by the prevalence of opiate drug use and high levels of long-term unemployment.

The Overview makes a number of recommendations in relation to data limitations and future research in this area. These include the following:

Data limitations

- In order to enhance our understanding of the way in which drug laws are enforced and the amount of resources being used in this area, data should be compiled on the number of drug-related 'stop and search' operations and the number of drug-related arrests which take place.
- Crime statistics should be compiled and reported as close to the local level as possible.

Drugs and crime

Irish research in this area remains limited both in focus and in quantity. Future research needs to begin from a broader theoretical framework, one which acknowledges the complexity of the relationship between drug use and crime.

- Research should investigate the pathways and factors which encourage some drug users into further drug use and offending behaviour.
- Research is urgently needed on the relationship between alcohol and violent crime.
- Given the evidence in Ireland and elsewhere of the positive connections between drug treatment and a reduction in offending behaviour, further research should be conducted on drug treatment programmes and among drug users in receipt of treatment to ascertain best practice in this area, and the obstacles to progress.
- Research is required on the relation between drug use, drug-related crime and gender.

The question as to the link between drugs and crime is of more than mere academic relevance. Different conceptions of the link determine the way in which society responds to drug users and also inform debates about drug legislation, crime prevention, drug treatment and law enforcement. The aim of this Overview is to review and analyse the available evidence on drugs and crime in Ireland so as to inform the development of effective responses which can contribute to the reduction of drug-related crime. *(Johnny Connolly)*

1. Stevens A, Trace M and Bewley-Taylor D (2005) *Reducing drug-related crime: an overview of the global evidence*. Oxford: The Beckley Foundation Drug Policy Programme. www.internationaldrugpolicy.net/

2. Connolly J (2006) *Drugs and crime in Ireland*. Overview 3. Dublin: Health Research Board.

Research is urgently needed on the relationship between alcohol and violent crime.

In 2004, prosecutions for simple possession made up 69 per cent of the total number of prosecutions, while supply offences accounted for 22 per cent of the total.

Drug use and labour market vulnerability

The National Economic and Social Forum (NESF) recently published a report offering practical recommendations to help create opportunities for vulnerable people in accessing training, education and better quality jobs in the labour market.[1]

The report states that 'labour market vulnerability is not an aberration or a left-over from the early 1990s – rather it continues to be generated today, even in a tight labour market' (p. X). Four key policy arenas where barriers interact to produce vulnerability are identified: economic, social, labour market and personal. The report identifies people with drug and alcohol dependencies as one of the marginalised groups particularly prone to experiencing labour market vulnerability on the basis that they face employment barriers such as poor education levels, low skills, inconsistent job histories and in some cases criminal records. In addition, the report states that there is a lack of employment support mechanisms to assist their progression.

There is no mechanism currently available that systematically collects data on unemployment levels among individuals with substance misuse issues. However, we do have some information from the National Drug Treatment Reporting System (NDTRS) that indicates employment levels among individuals reporting for treatment for problematic drug use. According to Long *et al.*,[2] the latest information suggests that employment levels among treated drug users aged 16–64 are much lower than those in the general population.

The 1996 report of the Ministerial Task Force on measures to reduce the demand for drugs,[3] the National Drugs Strategy 2001–2008,[4] and the Mid-Term Review of the National Drugs Strategy 2005[5] all highlight the need to link labour market training with drug treatment options. Since 1997/98, FÁS, Ireland's Training and Employment Authority, has been responsible for providing the bulk of labour market training for individuals in treatment for their drug use through the Community Employment (CE) scheme. However, a recent review of this training highlighted the many difficulties involved in progressing individuals towards labour market employment.[6] The review reported that, for a lot of individuals engaged in labour market training through the CE scheme, the issue of progression highlighted a fundamental contradiction, as what was in essence a labour market mechanism was being used to achieve rehabilitative objectives, sometimes at the most rudimentary level. For example, the review found that 'much activity centres on defined needs around literacy, numeracy and basic life skills. Many participants report commencing CE having only recently emerged from periods of profound chaos in their lives' (p. 42).

The NESF report also highlights the key role that early school leaving plays in exposing marginalised groups such as drug users to labour market vulnerability. Drawing on a report by the European Commission, it states that the rate of early school leaving in Ireland remains above the EU average. Data from the NDTRS indicate that, between 1998 and 2002 inclusive, an average of 26% of all cases being treated for problematic drug misuse in Ireland reported leaving school before the age of 15.[2]

The NESF report recommends an approach that can be used to address this vulnerability and progress individuals in training towards labour market participation. However, as identified in the review of FÁS involvement with drug users, not all individuals can engage with labour market training at the same level. Some require longer periods to adjust to the demands of a structured intervention, and it is questionable whether the FÁS CE model of vocational training is suitable to the needs of this group. However, for those who can engage with specific training and education modules, the NESF report provides a framework that incorporates an appreciation of the interacting factors that increase labour market vulnerability and highlights measures to improve the pathway of progression to the labour market. These include:

- locally based, integrated and inter-agency approaches
- client involvement in policy development and strategic planning
- individual training plans and one-to-one assessment and support
- input tailored to the educational and training needs and interests of the client

The report also recommends that service providers seek to match the skills and training needs of clients to the skills and job requirements of the labour market. In essence, this report provides a welcome opportunity for policy makers and drug treatment and reintegration service providers to consider ways of increasing progression opportunities for those individuals that are engaged with drug treatment services and are presenting for engagement in labour market training initiatives. *(Martin Keane)*

1. NESF (2006) *Creating a more inclusive labour market*. Report 33 Dublin: National Economic and Social Forum.
2. Long J, Lynn E and Kelly F (2005) *Trends in treated problem drug use in Ireland, 1998 to 2002*. Occasional Paper No. 17. Dublin: Health Research Board.
3. Ministerial Task Force (1996) *First report of the Ministerial Task Force on measures to reduce the demand for drugs*. Dublin: Stationery Office.
4. Department of Tourism, Sport and Recreation (2001) *Building on experience: National Drugs Strategy 2001–2008*. Dublin: Stationery Office.
5. Steering group for the mid-term review of the National Drugs Strategy (2005) *Mid-term review of the National Drugs Strategy 2001–2008*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
6. Bruce A (2004) *FÁS Community Employment schemes for local drugs task force areas*. Dublin: Unpublished report for FÁS.

GAA initiative on alcohol and substance abuse

Mr Brendan Murphy, national co-ordinator of the GAA's Alcohol and Substance Abuse Prevention (ASAP) programme.

As part of its strategy on drugs and alcohol, the Gaelic Athletic Association (GAA) recently appointed a national co-ordinator for its Alcohol and Substance Abuse Prevention (ASAP) programme. Brendan Murphy, formerly Regional Drugs Training Officer with the HSE Western Area, took up his new position in November 2005. He spoke recently to *Drugnet Ireland* about his work in implementing the GAA's strategy and the development of the organisation's policy in this area.

In June 2004 the GAA Task Force into Alcohol and Substance Abuse, following consultation with members of the association, health professionals and others, published a report[1] of its findings and recommended that the GAA should actively work towards reducing the level of drug and problem alcohol use in Irish society. The report recommended a comprehensive education programme on drugs and alcohol with an emphasis on young members. It also recommended the creation of a code of conduct for the serving of alcohol in clubs and at GAA functions and the development of guidelines in relation to advertising or sponsorship involving the drinks industry.

The Task Force, chaired by Galway All-Ireland-winning captain Joe Connolly, recognised the shortcomings in existing prevention programmes and its deliberations were informed by a health promotion approach to problem drug and alcohol use. It saw clearly the need to develop a broad programme which all members could contribute to and have a role in shaping. A major task facing the new co-ordinator of the ASAP programme is to set up the structure through which the GAA's policy will be implemented. This structure will comprise 32 county officers, each of whom will work with, but will not be part of, the association's county boards. All county officers will receive training in facilitating meetings and other skills. So far, six county officers have been appointed.

The county officers will assist Mr Murphy in selecting club officers and eventually there will be an officer attached to each of the country's 2,500 GAA clubs. Each officer will co-ordinate the development of the club's own drug and alcohol policy. The policy will be based on a common template but each club will have considerable autonomy in deciding what policies are appropriate to its particular circumstances and local conditions. An important element of club policy on alcohol and drugs will be an outline of how the club communicates on this issue with the Garda and with local HSE health promotion and drug and alcohol units. Each individual club policy must also outline appropriate actions in the areas of prevention, education (for both adults and juveniles) and responses to incidents.

While these structures are being put in place the GAA will be working on practical prevention and education initiatives. These will include delivering video segments to the mobile phones of young members, carrying a series of messages from well-known players from the members' own county team. This initiative anticipates more extensive use of 3G mobile phone technology.

The administrative structure of the GAA has served it well throughout its 120-year history. It has a presence in every parish in the country. Its development and administration and the promotion of its values depend on committed and energetic voluntary effort in all its 2,500 clubs throughout the country. This structure and outlook allow it to take on a very ambitious programme of prevention and education. The ASAP programme plans to establish a network to collect baseline data, using existing models such as the ESPAD or HBSC surveys, and monitor trends over the course of the programme. This could provide a very valuable, and possibly unique, insight into the effectiveness of this type of prevention and education programme. *(Brian Galvin)*

1. GAA Task Force into Alcohol and Substance Use (2004) *A report by the GAA Task Force into Alcohol and Substance Use*. Dublin: Gaelic Athletic Association.

Estimating the true prevalence of drug use in the population

In March 2006 the National Advisory Committee on Drugs (NACD) in Ireland and the Drug and Alcohol Information and Research Unit (DAIRU) in Northern Ireland published confidence intervals for the prevalence estimates from the 2002/2003 drug prevalence survey.[1,2] This article will help explain in non-technical terms the importance of confidence intervals and how to interpret the recently published figures.

The term 'prevalence' in the context of drug use refers to the proportion of a population who used a drug over a particular time period. Information on drug use among the population is usually gathered through surveys and prevalence is measured by asking respondents in a sample randomly drawn from the population to recall their use of drugs. For example, in Ireland, the lifetime prevalence (ever used drug in lifetime) of cannabis for adults (15–64 years) was estimated to be 17.4% in 2002/2003. Since this estimate is based on a sample, the true prevalence in the population may be different.

Provided a sample is 'representative' of the total population, prevalence information obtained from it can be used to infer the prevalence in the population with a certain degree of confidence. The representativeness of a sample refers to the extent to which it mirrors the population of interest. The calculation of a confidence interval provides us with upper and lower value limits that contain the true value with a degree of certainty. By convention, a 95% level of certainty is chosen for confidence intervals in drug prevalence surveys. For example, the recently published 95% confidence interval for lifetime prevalence of cannabis is reported as ranging from 16.3% to 18.4% (Table 1). Thus we can say that we are 95% confident that the true proportion of cannabis users in the population is in the range 16.3%–18.4%. In other words, the prevalence could be as low as 16.3% or as high as 18.4%. To obtain an exact prevalence figure, the entire population would have to be surveyed – which would be prohibitively expensive.

Table 1 shows the lifetime, last-year and last-month use of cannabis by adults, by region (former health board area). While some of the regional prevalence estimates are much higher than the national estimate and others are lower, the confidence intervals allow us to determine whether the regional estimates differ significantly from the national estimate. If the range of values for a regional estimate did not overlap the range of values for the national estimate, this would be regarded as a statistically significant difference (i.e., the difference is unlikely to be due to chance). For example, lifetime prevalence of cannabis in the East Coast Area ranges from 20.8% to 28.2%, while the national estimate ranges from 16.3% to 18.4%; thus, the East Coast Area estimate is regarded as statistically higher than the national estimate.

Figures 1a to 1c show the regions that have statistically higher or lower prevalence estimates for cannabis use compared to the national estimate. For lifetime use, only three regions have prevalence estimates statistically higher than the national estimate and five areas have statistically lower estimates (Figure 1a). For both last-year and last-month use, no region has an estimate statistically higher than the national estimate (Figures 1b and 1c). This is due to two factors: the low number of people who used cannabis in the last year or last month and the small number of people in each of the regional samples.

In general, the larger the sample the narrower the confidence intervals and the more precise we can

Table 1 Lifetime, last-year and last-month use (%) of cannabis by adults (15–64 years) by region (former health board area) in 2002/2003. Figures in brackets are 95% confidence intervals.

Region (former health board)	Use of cannabis		
	Lifetime % (95% CI)	Last year % (95% CI)	Last month % (95% CI)
East Coast Area	24.5 (20.8–28.2)	6.1 (4.1–8.2)	3.8 (2.2–5.5)
Northern Area	26.9 (23.3–30.4)	7.7 (5.5–9.8)	4.5 (2.9–6.2)
South West Area	23.2 (20.1–26.3)	7.3 (5.4–9.2)	3.9 (2.5–5.3)
Midland	10.7 (7.0–14.4)	2.8 (0.8–4.7)	1.0 (0.2–3.2)
Mid-Western	10.9 (7.9–13.9)	3.0 (1.3–4.6)	1.6 (0.4–2.9)
North Eastern	17.8 (14.1–21.4)	5.2 (3.0–7.3)	1.9 (0.6–3.2)
North Western	9.3 (5.8–12.8)	2.2 (0.4–3.9)	0.2 (0.0–1.9)
South Eastern	16.8 (13.6–20.0)	5.8 (3.8–7.8)	2.1 (0.9–3.4)
Southern	11.6 (9.2–13.9)	4.4 (2.9–5.9)	2.1 (1.1–3.2)
Western	12.0 (9.1–15.0)	2.0 (0.7–3.3)	1.3 (0.3–2.3)
Ireland	**17.4 (16.3–18.4)**	**5.0 (4.4–5.7)**	**2.6 (2.1–3.0)**

Estimating the true prevalence of drug use *(continued)*

be in estimating the true prevalence of drug use in the population. It is good practice to provide confidence intervals to indicate the level of precision associated with survey estimates. *(Hamish Sinclair)*

1. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2006) *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: first results (revised) from the 2002/2003 drug prevalence survey – Bulletin 1. Confidence Intervals*. Dublin: National Advisory Committee on Drugs.

2. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2006) *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: Health Board (Ireland) & Health and Social Services (Northern Ireland) results (revised) – Bulletin 2. Confidence Intervals*. Dublin: National Advisory Committee on Drugs.

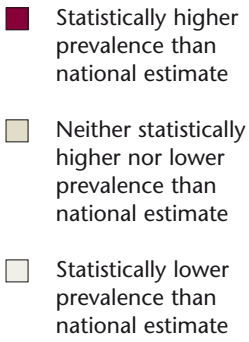


Figure 1a Lifetime use of cannabis by adults (15–64 years) by region in 2002/2003

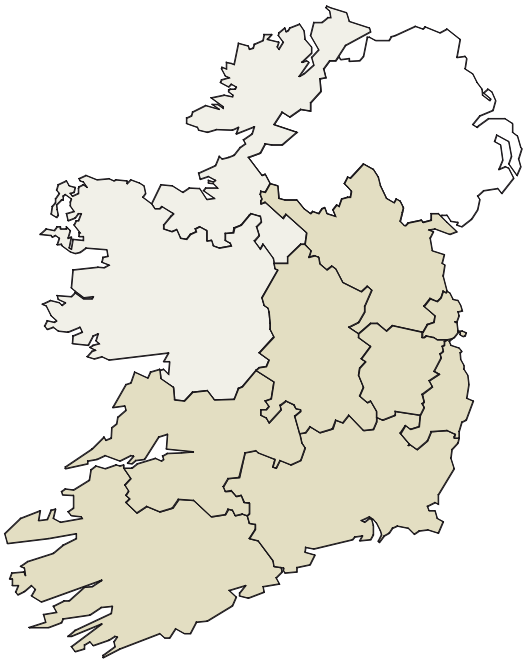


Figure 1b Last-year use of cannabis by adults (15–64 years) by region in 2002/2003

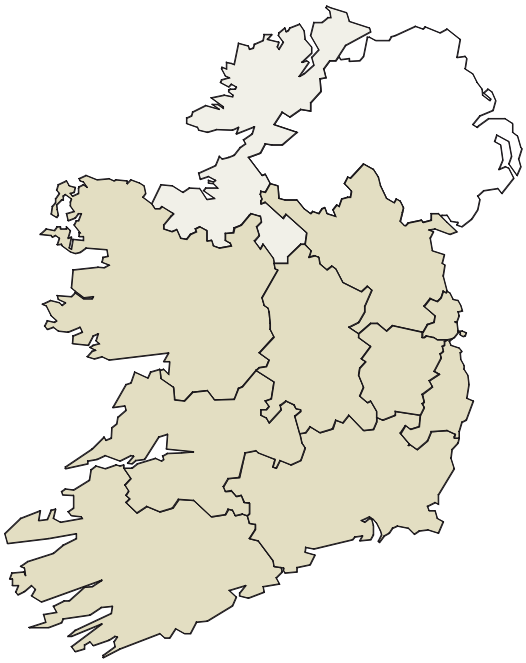


Figure 1c Last-month use of cannabis by adults (15–64 years) by region in 2002/2003

Homelessness and drug misuse: a continuing challenge for service providers

This article reports on progress made so far on actions pertinent to the association between homelessness and substance misuse or addiction contained in the documents *Homelessness: An Integrated Strategy* (2000)[1] and in *Homeless Preventative Strategy* (2002).[2]

The Integrated Strategy identified individuals leaving custodial and health-related institutional care (psychiatric care and care for vulnerable young people) as a group at risk of becoming homeless. Recent research in Ireland has demonstrated a strong association between drug misuse and homelessness among individuals in custody.[3] On the other hand, there is a lack of Irish research on the association between drug misuse, homelessness and people with experience of institutional health-related care, despite the fact that research into the homeless population in Ireland has reported drug misuse, mental health issues and being in care as factors associated with becoming and remaining homeless.[4,5]

Actions 9 and 11 of the 2000 strategy require statutory and voluntary agencies to provide a mix of suitable emergency accommodation for homeless women, couples, families and homeless persons with substance addictions, as well as high-support hostels for the last group. The recent review of the implementation of the Integrated and Preventative Strategies[6] reports that 'the supply, range and quality of emergency accommodation available … have increased significantly over the last five years' (p. 31). However, while this may be the case for most of the groups included under Actions 9 and 11, there is no specific information in this review to show that emergency accommodation has been made more available or more accessible to homeless individuals engaged in drug misuse. Indeed, recent research has shown that such individuals (a) continue to experience barriers to accessing emergency accommodation and (b) are resistant to using emergency accommodation for fear of escalating their drug use.[3,7] Research by Courtney[8] found that, although there was a reduction in the number of individuals sleeping rough in the Dublin area and the number of referrals of individuals with low-support needs had decreased, there was an increase in referrals of those with multiple needs, usually involving substance abuse and physical or mental health problems, which can result in chaotic or challenging behaviour. The lack of explicit policies on dealing with drug users and drug use among providers of homeless services is primarily responsible for these issues of accessibility to emergency accommodation,[7] with many services operating a policy of excluding active drug users.

The review acknowledges that dedicated hostels in the form of night shelters have been introduced in the Dublin area, primarily targeting the needs of individuals suffering alcohol addiction. But the review does not make explicit the availability or accessibility of these hostels for individuals engaged in drug misuse.[6]

An area where there has been welcome progress is the accommodation needs of ex-offenders. The *Homeless Preventative Strategy*, which developed from Action I in the Integrated Strategy, identified ex-offenders as being at risk of homelessness on leaving institutional custodial care. The review of the implementation of both strategies[6] reports that a specialist unit, the Homeless Offenders Strategy Team (HOST), has been established by the Probation and Welfare Service (PWS) to assist ex-offenders find accommodation. In addition, the Prison Service and the PWS are engaged in building and operating transitional housing units for ex-offenders; 34 such places have been developed. This is a welcome development, as research consistently shows that being homeless on release from custodial institutions exposes individuals to a high risk of relapsing into drug use.[9,10]

As part of the review of the homeless strategies[6] 33 homeless service users were interviewed between March and May 2005. Family breakdown and associated problems of alcohol and substance abuse were cited as the primary reasons for becoming homeless in the first instance. Many of the interviewees reported that they had relapsed when accommodated in homeless hostels after having been drug or alcohol free for a considerable period of time. A number of interviewees reported that they had to wait for six to nine months to join a methadone programme. This research again emphasises the important task facing statutory and voluntary service providers in tackling the strong association between drug misuse and homelessness. Despite the measures progressed so far, it would appear that major gaps in service provision remain, particularly in relation to individuals with multiple needs, including active drug users. *(Martin Keane)*

1. Department of the Environment and Local Government (2000) *Homelessness: An Integrated Strategy*. Dublin: Department of the Environment and Local Government.

2. Departments of Education, Environment, and Health and Children (2002) *Homeless Preventative Strategy*. Dublin: Stationery Office.

3. Seymour M and Costello L (2005) *A study of the number, profile and progression routes of homeless people before the court and in custody*. Dublin: Probation and Welfare Service.

4. Smith M, McGee H and Shannon W (2001) *One hundred homeless women: health status and health service use of homeless women and their children in Dublin*. Dublin: Royal College of

Homelessness and drug misuse *(continued)*

Surgeons in Ireland and the Children's Research Centre, Trinity College Dublin.

5. Feeney A, McGee H, Holohan T and Shannon W (2000) *The health of hostel-dwelling men in Dublin: perceived health status, lifestyle and health care utilisation of homeless men in south inner city Dublin hostels*. Dublin: Royal College of Surgeons in Ireland and Eastern Health Board.

6. Fitzpatrick Associates Economic Consultants (2006) *Review of the implementation of the government's Integrated and Preventative Homeless Strategies*. Report submitted by to the Minister for Housing and Urban Renewal. Dublin: Stationery Office.

7. Lawless M and Corr C (2005) *Drug use among the homeless population in Ireland*. Dublin: Merchants Quay Ireland.

8. Courtney R (2005) *Review of temporary accommodation*. Dublin: Homeless Agency.

9. Hickey C (2002) *Crime and homelessness*. Dublin: Focus Ireland and PACE.

10. O'Loingsigh G (2004) *Getting out, staying out: the experiences of prisoners upon release*. Dublin: Community Technical Aid.

New mental health policy distances its link with the addiction services

The report of the Expert Group on Mental Health Policy *A Vision for Change* was published on 24 January 2006.[1] The report details a comprehensive model of mental health services in Ireland. This model will emphasise the development of mental health services in the community over the next five to ten years.

According to the expert group, 'individuals [adults and children] whose primary problem is substance abuse and who do not have [other] mental health problems will not fall within the remit of mental health services'. In a departure from the international classification system, substance abuse (dependence) will no longer be included among the categories of mental health problems in Ireland.

According to the report, the major responsibility for the care of those with substance abuse (dependence) lies outside the mental health services, and rests with separate services that have their own funding structure within Primary, Community and Continuing Care (PCCC) in the Health Service Executive. Historically, such funding was allocated for the care of those with drug dependence rather than alcohol dependence. The report does not clarify how the mental health services will reassign to the PCC function the staff and finance currently used to address alcohol dependence in the mental health services.

The expert group states that beds in acute psychiatric facilities 'should not be used for routine detoxification, which should be done on an outpatient basis', and goes on to state that 'more complex detoxification should take place in acute general hospital facilities'. The policy report does not give the rationale behind this approach, nor does it indicate who will supervise such detoxifications in the general hospital.

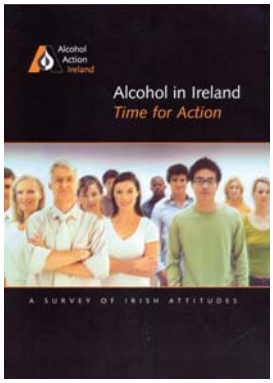
In relation to the issue of substance abuse (dependence), the report recommends that:

- Mental health services for both adults and children will be responsible for providing mental health services to individuals who have another mental illness in addition to their substance abuse (dependence).
- General adult community mental health teams will care for adults with substance abuse and another mental health problem when the mental health problem is the primary problem.
- Specialist substance abuse mental health teams for adults with complex severe substance abuse and mental disorders will be established. These specialist teams should establish clear links with local community mental health services, and clarify pathways in and out of their services.
- Two additional specialist substance abuse teams for children with substance abuse (dependence) and mental disorders should be established outside Dublin.
- A post for a national co-ordinator should be established in the PCCC function of the Health Service Executive. According to the policy document, the co-ordinator should develop standards for the delivery of interventions to address alcohol and drug abuse (dependence) in Ireland and establish how such interventions will be linked to mental health.

(Jean Long)

1. Expert Group on Mental Health Policy (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: Stationery Office.

Public attitudes to alcohol in Ireland: a recent survey



In April 2006, Alcohol Action Ireland published the findings from an omnibus survey by Millward Brown IMS of public attitudes to alcohol consumption and to possible policy changes required to reduce alcohol-related harm.[1] Using a quota-based sampling method, 1,093 adults aged 18 years or over were interviewed between 20 October and 3 November 2005. The sample was quota-controlled by age, gender, social class and geographical region to ensure representation of the adult population living in Ireland.

The main findings of the survey are discussed below.

Alcohol-related harm

Two thirds (66%) of all respondents personally knew someone who had a problem with alcohol consumption, and over half (57%) had been concerned about someone's alcohol use, which suggests that these people had a closer relationship with the person with the problem. When respondents were asked if they or anyone close to them had experienced an injury, harassment or intimidation caused by their own or someone else's use of alcohol, 44% answered 'Yes'.

a majority (82%) of respondents believed that the current level of alcohol consumption in Ireland was a problem

Given this high level of perceived or experienced harm, it is not surprising that a majority (82%) of respondents believed that the current level of alcohol consumption in Ireland was a problem and that a similar majority (85%) believed that our cultural attitude towards drinking alcohol and the behaviour that goes with it should change. These beliefs were more prevalent among women than men. Just over half (51%) of all respondents believed that the government was not doing enough to address the problems caused by alcohol use; 23% were undecided on this question. The response was generally consistent across gender and age groups.

Taxation and drink driving

While taxation increases are never popular, just over half of the respondents (54%) stated they would accept an increase in excise duty or tax on alcohol if it was 'specifically put towards an initiative that led to a reduction in alcohol-related harm'. A majority (87%) of respondents were in favour of full nationwide introduction of random breath testing to detect drink-drivers. The survey report notes that support for random breath testing was strong (84%) even among rural respondents who generally have fewer transport options when socialising outside the home. However, nearly three-quarters (72%) of all respondents did not believe that the gardaí have enough resources to enforce the current law in relation to drink-driving.

Advertising and sponsorship

While support for an outright ban on all forms of alcohol advertising was low (44% in favour), a much larger proportion (72%) wished to see alcohol advertising permitted only after 9.00 pm, when children's peak television-viewing time was over. Only 39% of respondents agreed that sponsorship of sports by the alcohol industry should be brought to an end; 35% opposed the idea; and 26% were undecided. More women than men agreed with a ban on sport sponsorship (45% compared to 33%).

Alcohol availability

Only one-third (33%) of respondents believed that the gardaí have sufficient resources to enforce the current law governing pub opening hours. A majority (71%) believed that allowing alcohol to be sold via the phone or internet would make it easier for under-18s to buy alcohol. Again, a large majority (74%) of respondents did not believe that the gardaí had enough resources to ensure that the law governing sales of alcohol to minors was enforced.

Treatment interventions

A majority (76%) of respondents were in favour of health and other professionals asking questions to identify problem drinking at an early stage in settings where a person showed signs of alcohol-related harm. Only a small proportion (3%) where opposed to this proposal, while 21% were neutral on the issue. Repeated attendance at accident and emergency (A&E) departments by a person under the influence of alcohol can be an indicator of an alcohol-related problem. Again, a majority (61%) of respondents were in favour of A&E departments having a specific service in place to refer patients with persistent alcohol-related problems. It is interesting to note that over one-third (37%) did not feel that such a service should be the responsibility of the A&E department.

Alcohol agency

A majority of respondents (85%) believed that the government should set up an agency with specific responsibility for tackling alcohol-related problems.

The findings of the survey suggest that there is widespread public support for measures such as random breath testing, identifying problem drinking at an early stage and restricting alcohol advertising to after 9.00 pm. Less popular, but still supported by a majority of the public, are measures such as an A&E referral service for patients with persistent alcohol-related problems and an increase in excise duty or tax on alcohol. There was also a general belief that the gardaí did not have sufficient resources to enforce the law regarding drink-driving, opening hours and the sale of alcohol to minors. *(Hamish Sinclair)*

1. Alcohol Action Ireland (2006) *Alcohol in Ireland: time for action. A survey of Irish attitudes*. Dublin: Alcohol Action Ireland.

Health Service Executive facilitates workshop on cocaine

On 3 May 2006 the Heath Service Executive (HSE) organised a workshop on cocaine, bringing together HSE staff and representation from the voluntary, community and statutory sectors. Opening the workshop, Alice O'Flynn, National Care Group Manager for Social Inclusion, stated that the growing problem of cocaine was an important issue for the HSE. An overview of the workshop was given by Cathal Morgan, HSE National Drugs Strategy manager. The aims of the workshop were to:

- Provide an overview of prevalence in relation to cocaine (including crack) use.
- Identify current key responses in relation to cocaine.
- Identify models of best practice based on research evidence.
- Discuss future responses to cocaine.

The workshop began with a series of presentations followed by group work.

Dr Eamon Keenan, clinical director of the HSE South Western Area Addiction Services, presented data on the prevalence of cocaine use in the general population and on treatment for problem cocaine use from 1998 to 2003. The number of treated cases reporting problem cocaine use increased considerably over this period. Of note, a substantial and increasing number of treated cases reported cocaine as an additional problem drug. Dr Keenan highlighted the need for more timely information in respect of both prevalence and treatment figures.

Dr Richard Maguire, principal biochemist at the Drug Treatment Centre Board, reported a rise in the number of methadone clients testing positive for cocaine use between 1998 and 2005. His findings mirrored the trend in cocaine use observed in the treatment data on additional problem drugs.

Detective Superintendent Barry O'Brien, Garda National Drugs Unit, presented the most recent data on cocaine and diamorphine (mainly heroin) offences and seizures. He reported that cocaine offences (as a proportion of all drug offences) had increased almost sevenfold between 2000 and 2005, from 2% to 13%, while diamorphine offences had remained high but the trend was relatively stable, increasing from 9% to 11% over the same time period. In terms of cocaine and diamorphine seizures, similar trends were observed. Cocaine was now being seized in many towns throughout the country.

Tony Geoghegan, director of Merchants Quay Ireland, gave a presentation on the treatment of cocaine from the voluntary drug treatment perspective and reported an increase in the number of cocaine users attending harm-reduction services.

Anna Quigley, manager of CityWide, presented the current effects of cocaine use on communities in Dublin. She said that the cocaine market is based in pubs or operates through mobile phone contact. According to Ms Quigley, alcohol and cocaine use are closely associated. She highlighted a number of social and economic consequences of cocaine use, such as debt, violence and insecurity.

Dr Brion Sweeney, clinical director of the HSE Northern Area Addiction Services, presented the evidence base for the treatment of problem cocaine use and stated that cogitative behavioural therapy in conjunction with other interventions was the most successful form of treatment. He went on to state that prompt, accessible and tailored interventions increased the effectiveness of such treatment. He pointed out that the evidence indicated that the use of medication in the treatment of cocaine dependence had little effect, but that new developments were expected in this area.

Following the presentations, participants were divided into small groups and asked to respond to a series of questions. Each group was asked to prioritise four key principles that they considered important in responding to the issue of cocaine. In addition, each group was asked to suggest ideas for a follow-up to the current workshop.

A number of common themes came out of the feedback from the different groups. Among these were:

- The response to the growing cocaine problem requires a co-ordinated approach, involving statutory, voluntary and community groups.
- The perception of cocaine as a 'clean and safe' drug needs to be changed.
- The availability of cocaine in pubs tends to link the drug with alcohol and gives it an 'acceptability' which needs to be addressed.
- Appropriate outreach services need to be developed to bring difficult-to-reach cocaine users into contact with treatment services.
- Approaches to treatment need to be timely and evidence based.
- Existing treatment services need to be enhanced, rather than new services specifically for cocaine created.
- More timely information is required to monitor, at an early stage, the emergence of new drugs and the changing patterns of current drug use.

Acknowledging the success of this event, participants felt that a follow-up workshop should be organised later in the year to review progress. At the close of the meeting, Cathal Morgan thanked participants and indicated that the HSE would produce a report on the day's proceedings and that action would be taken on the basis of the workshop outcomes. *(Hamish Sinclair and Jean Long)*

Inequality and the stereotyping of young people

Recent research published by the Equality Authority[1] highlights the ways in which a selection of teenagers believe they are negatively perceived and treated by adults across Irish society. The report is based on focus group discussions with some 90 teenagers during May and June 2005 and includes the views of young asylum seekers, travellers, people with disabilities and lesbian, gay, bisexual and transgender youth. Contact with the young people was facilitated through the National Youth Council of Ireland (NYCI). The report also includes findings from a case study of stereotyping of young people in the Irish media.

The media

The media were most commonly identified by the focus groups as creators of negative stereotypical images of young people by constantly associating them with crime, deviance, disorder and drug and alcohol problems. Empirical findings from the case study of the Irish media supported this view but also highlighted the gender differences in media representations, with young men often portrayed in criminal and deviant terms and young women in terms of victimhood and vulnerability.

The gardaí and the security industry

Evidence of poor relationships with the gardaí, and the view that the gardaí had a poor opinion of young people, dominated several of the focus group discussions. However, some young people reported that their relations with some individual community gardaí were quite positive. Young people reported being treated differently from adults by security personnel in shops and shopping centres in terms of being followed and observed. They felt that security personnel discriminated against them because of their age and their clothes.

Politicians

With very few exceptions, the young people's experiences and opinions of politicians and their perceptions of politicians' attitudes towards young people were negative. Politicians were seen as representing the views of the adult generation and as dismissing young people as unimportant. Young people felt that not having the vote until they were aged 18 rendered them voiceless and unimportant to the politicians.

Teachers and school

The young people felt that they were not being treated equally by their schools or teachers. They gave examples of different rules about the use of mobile phones applying to teachers and to students in the classroom. Young people felt that they did not have a voice in how their schools were being run. They felt that school rules should be negotiated between young people and the school authorities instead of being imposed.

The local community

Young people reported constant 'hassle' in public from adults, especially when 'hanging around' in groups on their local estates. They accepted that meeting outdoors in groups made them more visible, but explained that they had few alternative places to meet with their peers. Recent research in Scotland by Seaman *et al.*[2] highlights the benefits young people derive from congregating with their peers; for example, the feeling of safety from being part of the 'gang' as their friends often provide them with information about the risks and safety precautions required around certain estates.

The importance of the peer group among teenagers is reflected in the quantity of time they spend 'hanging out' together and the importance they place on mutual support. Recent research by Lalor and Baird[3] among a sample of adolescents in Co Kildare revealed that a favoured activity among respondents was 'hanging out with friends', with over half the sample spending between five and fourteen hours per week with friends. Close friends and peers were listed as being key sources of social support that young people turn to when they encounter problems.

Although the views and experiences raised by young people in this research by the Equality Authority cannot be generalised to the wider population of young people, they do provide an opportunity for youth workers, teachers, Garda Juvenile Liaison Officers and other professionals working with young people to reflect on their methods of engagement. Teachers and Garda Juvenile Liaison Officers often deliver drug education and awareness programmes to young people of a similar age and profile to this group. The perception by young people that they are not respected by such figures has implications for the effectiveness of such programmes. It might be more effective to train young people themselves to deliver drug prevention programmes. This would go some way to creating conditions of negotiation between young people and significant adults in society around a key issue of behavioural change in relation to substance misuse. *(Martin Keane)*

1. Devlin M (2006) *Inequality and the stereotyping of young people.* Dublin: The Equality Authority.

2. Seaman P, Turner K, Hill M, Stafford A and Walker M (2006) *Parenting and children's resilience in disadvantaged communities.* London: National Children's Bureau.

3. Lalor K and Baird K (2006) *Our views – Anybody listening? Researching the views and needs of young people in Co Kildare.* Kildare: Kildare Youth Services.

Keeping drugs out of prisons: a review of the Irish Prison Service drugs policy and strategy

A new strategy document published by the Irish Prison Service (IPS) entitled 'Keeping drugs out of prisons' proposes to tackle the use of illicit drugs in Irish prisons by focusing on supply elimination and demand reduction.[1] To implement this new strategy, the IPS recognises the need for quality research on the extent and nature of drug misuse within Irish prisons. In his address to the annual conference of the Prison Officers' Association in Killarney on 4 May 2006 the Minister for Justice Michael McDowell reiterated his policy of 'zero tolerance' in relation to the use of drugs in prisons.[2]

Despite a lack of published data, a number of studies conducted with prisoners indicate that there is a readily available supply of drugs in some Irish prisons.[3,4,5] Reports suggest that visits by friends and family and the throwing of drugs over perimeter walls are among the supply routes used in Mountjoy prison. Another possible source of supply is the trafficking of drugs by prison staff. Responding to a claim by the Inspector of Prisons, Mr Justice Dermot Kinlen,[6] Minister McDowell has confirmed that a number of prison officers are currently under suspension and facing criminal proceedings in relation to drug smuggling.[7] Anecdotal evidence suggests that vulnerable prisoners are pressurised into receiving drugs from visitors or picking up packages of drugs thrown over the perimeter wall. The new strategy document recommends that searches after visits should not be confined to known drug users but should include prisoners who could be intimidated into receiving drugs on a visit.

Current measures in place in Mountjoy prison to prevent the supply of drugs during visits include CCTV cameras, screened visits whereby physical contact between prisoner and visitor is prevented and random searches of prisoners. Prisoners are required to nominate visitors, who must produce identification when entering the prison, in order to reduce the number of visitors giving false names in an attempt to smuggle in drugs. These measures have been included in the new IPS policy and strategy document and are to be extended to all prisons along with new initiatives, including a recommendation that physical contact between visitors and prisoners should not be permitted unless sanctioned by the governor and that any unscreened visits should be booked in advance.

Mountjoy prison authorities and the Garda Síochána operate in partnership to prevent drugs being thrown into the prison grounds from outside; officers patrol yard areas to intercept packages and prevent prisoners collecting them; and efforts are made to arrest individuals attempting to pass drugs over the perimeter walls from outside the prison. Cases where a prison officer is suspected of smuggling drugs are handled by the gardaí.

A prisoner found to be in possession of illegal drugs is liable to a number of sanctions: evening recreation may be withdrawn for a number of days; future visits may be screened for a given period of time; or remission may be curtailed. The maximum punishment that can be applied is a loss of 14 days' remission and the loss of all privileges for two months. Similar punishments apply where a prisoner commits a drug-related offence in prison, such as possession of a syringe, sharing a toilet cubicle for drug use or giving a false name to obtain medication.

Searches are a significant part of the attempt to reduce the supply of drugs into Mountjoy prison. Prisoners being committed to prison and those returning from temporary release are strip-searched to ensure they are not carrying drugs on their person. Two random searches, where the prisoner and his cell are searched, are conducted on each landing within the prison every day. Prisoners are also sometimes searched after visits. However, prison officers do not generally search visitors. Where a visitor is suspected of supplying drugs, the prison will alert the gardaí who handle the matter of searching visitors on their way into the prison. As part of the IPS strategy, passive canine units will be made available to all closed prisons to assist in the detection of drugs within the prison or in the possession of visitors.

The IPS strategy also provides for the introduction of mandatory drug testing (MDT) by the end of 2006. This will involve 5% to 10% of prisoners being randomly selected for drug testing each month. A prisoner who refuses to take the test or tests positive for drugs will incur sanctions.[8]

The IPS recognises that the best way to reduce the demand for drugs in prison is by providing a range of evidence-based treatment options. The prison service has outlined three core tasks to support drug treatment and rehabilitation:

1. Identifying and engaging with drug users
2. Providing treatment options
3. Ensuring continuity of treatment and care following release.

The core treatment options are:

- assessment and through-care planning
- information, education and awareness programmes
- opiate replacement therapies

a number of studies conducted with prisoners indicate that there is a readily available supply of drugs in some Irish prisons

Mountjoy prison authorities and the Garda Síochána operate in partnership to prevent drugs being thrown into the prison grounds from outside

Keeping drugs out of prisons *(continued)*

As part of its new strategy, the IPS aims to strengthen research in the area of drug misuse in prisons

- methadone detoxification and reduction programmes
- symptomatic treatment options
- mental health care
- voluntary drug testing units
- motivational interventions.

A number of specialised treatment options will also be available in designated prisons, including cognitive behavioural therapy, the 12-step Minnesota model, peer-support programmes and specialised programmes to address drug misuse and re-offending. The treatment approaches will be adapted for prisoners with special needs, including drug users with mental health problems or hepatitis C. The IPS strategy states that there will be a close link between drug treatment services and other health care services to ensure adequate management of mental illnesses and blood-borne viral diseases. The IPS has no harm-reduction strategy for those drug users who continue to use drugs.

At present there are no official statistics regarding the supply of drugs in Irish prisons and no studies have been conducted on the illicit drug market in Irish prisons. As part of its new strategy, the IPS aims to strengthen research in the area of drug misuse in prisons. This research will be based on partnership between the relevant statutory and non-statutory bodies. Policies will include:

- commissioning and encouraging research on drug misuse in prisons
- evaluating all programmes and interventions
- making all research data available to and liaising regularly with the relevant bodies
- investigating systems to identify and manage patient outcome data
- evaluating the effectiveness of drug interventions using intervention outcome information.

Research will be used to inform policy makers and service providers in implementing the IPS strategy and to develop models of best practice. *(Johnny Connolly, Sinead Foran and Jean Long)*

1. Irish Prison Service (2006) *Keeping drugs out of prisons: drugs policy and strategy*. Dublin: Irish Prison Service.
2. Address by Minister for Justice Michael McDowell TD to the Annual Conference of the Prison Officers' Association, www.progressivedemocrats.ie/press_room/1787/
3. O'Mahony P (1997) *Mountjoy prisoners: a sociological and criminological profile*. Dublin: Department of Justice.
4. Long J, Allwright S and Begley C (2004) Prisoner's views of injecting drug use and harm reduction in Irish prisons. *International Journal of Drug Policy*, 15: 139–149.
5. Dillon L (2001) *Drug use among prisoners: an exploratory study*. Dublin: Health Research Board.
6. Lally C (2006, 6 May) Five prison officers suspected of drug smuggling. *The Irish Times*. Retrieved 15 May 2006 from www.ireland.com
7. Bracken A (2006, 6 May) McDowell confirms suspensions. *The Irish Times*. Retrieved 15 May 2006 from www.ireland.com
8. For a review of mandatory drug testing, see Connolly J (2005) Prison rules provide for mandatory drug testing. *Drugnet Ireland*, Issue 15: 15.

Information for new communities

An exploration by Corr[1] of drug use among new communities in Ireland reported that drug users from new communities were generally unaware of drug service provision in Ireland, and were doubtful of the confidentiality of information held by such services. The report recommended that information material produced for these communities highlight the range of services provided in Ireland and their confidential nature. It also recommended that the information be translated into appropriate languages and distributed in places drug users from new communities were most likely to frequent.

Merchants Quay Ireland (MQI), the largest voluntary sector provider of homeless and drugs services in Ireland, has taken the lead in this regard and recently produced information leaflets in English, Polish and Russian detailing service provision at MQI. The leaflets contain details on services for drug users such as needle exchange, methadone prescribing, residential drug-free services, and settlement and integration services providing help with accommodation and training and employment support. Also included are details of the services for homeless people, including crisis support, meals service, primary healthcare and a women's health programme. Opening hours and direct-dial phone numbers specific to each service are provided. The services are open to all individuals experiencing drug use or homelessness. Service providers in the drugs area wishing to avail of these leaflets for dissemination to their clients are invited to contact MQI for arrangements. You may contact Niamh Randall at 01 6790044 for further information. *(Martin Keane)*

1. Corr C (2004) *Drug use among new communities in Ireland: an exploratory study*. Dublin: Merchants Quay Ireland.

Substance use among the Irish prison population

The first systematic and representative survey of mental health among the Irish prison population using standardised research diagnostic methods was implemented in 2003.[1] Using the schedule for schizophrenia and affective disorders (lifetime version) and the severity of dependence questionnaire, researchers assessed the mental health of five distinct samples within the prison population. The samples were 615 (7%) men committed to prison, 232 (50%) men in custody on remand,[2] 438 (15%) sentenced men, 94 (9%) women committed to prison and 92 (90%) women in prison. In total, 1,471 individuals participated in the study, of whom 1,285 were men and 186 were women; one woman commenced but did not complete the study. Response rates for the five samples ranged between 71% and 90%. The sample of men serving sentences was representative of the population of men serving sentences (excluding life sentences) with respect to age, length of current sentence and time spent in prison.

According to the authors, between 61% and 74% of prisoners had a substance use disorder at the time of the survey, with little difference between the proportions of men and women (Table 1).

Between 12% and 23% of men had a mental illness (excluding a substance use disorder). The rate of current mental illness for women was not reported. Of note, 29% of female committals and 39% of sentenced or remanded women had had a mental illness in the six months prior to the study.

The authors reported that a number of prisoners with mental illness also had a substance misuse disorder. The rate of drug dependence was higher than the rate of alcohol dependence among male committal and sentenced prisoners. Higher proportions of women than men were attending drug treatment (including methadone substitution) prior to committal. *(Jean Long)*

1. Kennedy H, Monks S, Curtin K, Wright B, Linehan S, Duffy D *et al.* (2005) *Mental illness in Irish prisoners: psychiatric morbidity in sentenced, remanded and newly committed prisoners*. Dublin: National Forensic Mental Health Service.

2. Linehan S, Duffy D, Wright B, Curtin K, Monks S and Kennedy H (2005) Psychiatric morbidity in a cross-sectional sample of male remanded prisoners. *Irish Journal of Psychological Medicine*, 22 (4): 128–132.

Table 1 Rates of current other mental illnesses, with 95% confidence intervals, attendance at drug treatment prior to committal and current methadone substitution in the Irish prison population in 2003

	Male committal prisoners[1]	Male remand prisoners[2]	Male sentenced prisoners[1]	Female committal prisoners[1]	Female sentenced and remand prisoners[1]
	(615)	(232)	(438)	(94)	(92)
			% (95% CI)		
Substance use disorder	60.6 (56.7–64.4)	65.6 (61.5–69.5)	73.7*	65.6 (55.5–74.5)	–
Alcohol abuse and dependence	36.2 (32.2–39.8)	34.7 (30.9–38.8)	–	–	–
Alcohol dependence	23.4 (20.2–26.9)	27.6 (24.0–31.5)	45.1*	–	–
Drug dependence	32.8 (29.5–37.0)	43.3 (39.3–47.6)	58.8*	–	–
Mental illness (excluding substance use disorder)	11.9 (9.6–14.8)	19.0 (14.4–24.5)	22.6*	–	–
Co-morbid substance use and mental illness	7.4 (–)	–	–	–	–
Attended drug treatment prior to committal	16.5	12.2	5.5	35.5	29.3
Currently receiving methadone substitution	16.7	14.3	3.9	35.5	34.8

– Not reported
* Weighted percentage

Northern Ireland launches combined alcohol and drugs strategy

While more complex than the simple linear approach adopted in Ireland's National Drugs Strategy, arguably the NSD framework will prove more flexible and adaptable.

In 2001 the Northern Ireland administration adopted a 'joint implementation model' for its alcohol and drugs strategies.[1] In 2005 it published the results of a review of the two strategies and their joint implementation.[2] Twelve months later, on 8 May 2006, it took the next step, launching a combined strategy – *New Strategic Direction for Alcohol and Drugs 2006–2011* (NSD).[3]

Professor Howard Parker, who undertook the review of the two strategies and their implementation,[2] reported that the majority of stakeholders were in favour of merging the alcohol and drug strategies as alcohol was 'routinely marginalised in terms of investment' (p. 45). While some thought tobacco should be included, others feared this might lead to an over-emphasis on the health aspects and marginalise other components such as enforcement or community safety.

Parker also found that stakeholders strongly supported joint implementation. Local practitioners recognised the interplay of alcohol and drugs in their work and, at a policy level, the overlaps between the youth and criminal justice systems, and prison and workplace policies, were recognised. Parker also noted that 'in such a small country joint implementation is necessary to produce economies of scale' (p. 45).

The 'overall aim' of the combined strategy (NSD)[3] is 'to reduce the level of alcohol and drug-related harm in Northern Ireland'. Four 'overarching long-term aims' focus on demand-reduction measures in relation to both alcohol and drugs in the areas of treatment, harm reduction, awareness, and prevention. There is just one over-arching long-term aim on the supply side – to 'reduce the availability of illicit drugs in Northern Ireland'. An annual progress report will be published, reporting against a series of 'key indicators', nine each for alcohol and for illicit drugs.

The authors of the NSD have designed a planning framework based on a 'logic model'. While more complex than the simple linear approach adopted in Ireland's National Drugs Strategy,[4] arguably the NSD framework will prove more flexible and adaptable. It is constructed around three inter-related components:

- Five pillars (prevention and early intervention; treatment and support; law and criminal justice; harm reduction; and monitoring, evaluation and research) provide the 'conceptual and practice base', i.e. identify the inputs to be made by service providers.
- Two themes (children, young people and families; and adults and the general public) provide for an 'integrated and co-ordinated approach to be developed incorporating elements of the five pillars as appropriate', i.e. ensure a client focus.
- Fourteen key priorities (including development of a four-tier service model and children's services; promoting good-practice education and prevention programmes; targeting those at risk and vulnerable; addressing under-age and binge drinking; reducing illicit drug availability and use; tackling anti-social behaviour; addressing community issues; developing effectiveness indicators for treatment; supporting harm-reduction approaches; and developing the workforce) will 'form the cornerstone of work over the next five years and reflect the issues identified as of crucial importance through the Review and the extensive pre-consultation exercise', i.e. ensure the relevance of the NSD.

To draw these components together in pursuit of the overarching long-term aims of the NSD, the various work programmes and activities are grouped under eight outcomes:

1. Children, Young People and Families (Treatment and Support)
2. Children, Young People and Families (Prevention and Early Intervention)
3. Adults and the General Public (Treatment and Support)
4. Adults and the General Public (Prevention and Early Intervention)

Alcohol – Key indicators

- Numbers referred to treatment
- Hospital admissions – primary and secondary diagnosis
- Alcohol-related deaths
- Binge drinking target
- Prevalence (hazardous drinking; problem drinkers)
- Per capita consumption or expenditure
- Alcohol-related crime
- Drink-driving
- Public perceptions of alcohol as a social problem

Drugs – Key indicators

- Numbers referred to treatment
- Hospital admissions – primary and secondary diagnosis
- Drug-related deaths
- Blood-borne viruses among injecting drug users
- Prevalence (including problem prevalence)
- Drug-related crime
- Drug-driving
- Disruption of supply markets
- Public perceptions of drugs as a social problem

NI alcohol and drugs strategy *(continued)*

5. Adults and the General Public (Anti-Social Behaviour)
6. Monitoring, Evaluation and Research
7. Workforce Development
8. Other

Timeframes for the achievement of these outcomes, comprising short-term (18-month), medium-term (3-year) and long-term (5-year) outcomes, are specified. During the lifetime of the NSD, these outcomes will be measured and the overall success or otherwise of achieving the long-term aims will be measured by the Key Indicators described above.

The structure of institutional mechanisms to oversee the implementation and co-ordination of the NSD is based on the same principles as those applied in Ireland's National Drugs Strategy. One innovation is the appointment of four 'advisory groups' – on children, young persons and families; on treatment and support; on law and criminal justice; and on binge drinking. These advisory groups will advise the New Strategic Direction Steering Group (the equivalent of our National Drugs Strategy Team) in respect of the particular issues, comment on particular work towards the outcomes of the NSD, and make recommendations as to future work and directions. Stakeholders and local communities, including service users, will be represented on these advisory groups. *(Brigid Pike)*

1. *Model for the Joint Implementation of the Drug and Alcohol Strategies* (May 2001) www.dhsspsni.gov.uk/jointdrug.pdf

2. H Parker (2005) *Better managing Northern Ireland's alcohol and drug problems – A review of the NI alcohol and drug strategies and the efficiency and effectiveness of their implementation* (March 2005) www.dhsspsni.gov.uk/drugs-alcohol-Report-NI-review.pdf

3. *New Strategic Direction for Alcohol and Drugs 2006–2011* (May 2006) www.dhsspsni.gov.uk/nsdad-finalversion-may06.pdf

4. *Building on experience: National Drugs Strategy 2001–2008.* Dublin: Department of Tourism, Sport and Recreation. www.pobail.ie/en/NationalDrugsStrategy/NationalDrugsStrategyOverview/file,2229,en.pdf

Self-reported substance use by women attending the Coombe Women's Hospital

Barry and colleagues[1] completed a study estimating the prevalence of alcohol, cigarette and illicit drug use by women attending the Coombe Women's Hospital between 1988 and 2005. The researchers examined the association between substance use and immediate outcomes for the newborn baby in the light of the recommendations of the *Second Report* of the Strategic Task Force on Alcohol[2] that deal with alcohol use and pregnancy. These were:

- Encourage pregnant women and women who are planning to become pregnant to avoid alcohol consumption, especially during the critical first trimester of pregnancy.
- Require a health-warning label on all alcohol products and alcohol promotional materials (p.39)

Anonymous data were extracted from a computerised database maintained by nursing and clerical staff at the hospital. In June 1999, some questions on the database were revised and new questions were added. This article presents results from 1 June 1999 to 30 March 2005.

Table 1 presents alcohol use before and during pregnancy between 1999 and 2005. Of the 36,108 women who consumed alcohol prior to pregnancy, 4,752 (13.2%) stopped during their pregnancy. Of the 3,947 women who consumed six or more units per week prior to becoming pregnant, only 876 (22%) stopped drinking during their pregnancy; this is a matter of concern. Level of alcohol use during pregnancy was not positively or negatively associated birth weight or the baby's ability to breathe spontaneously at birth.

Table 1 Alcohol use before and during pregnancy, 1999 to 2005 (43,318 women)

	Before pregnancy	During pregnancy
Amount of alcohol consumed	**Number (%)**	
No alcohol	7,210 (16.6)	11,962 (27.6)
1 to 5 units per week	28,197 (65.1)	24,300 (56.1)
6 or more units per week	3,947 (9.1)	3,071 (7.1)
Not recorded	3,964 (9.2)	3,985 (9.2)

Self-reported substance use by women attending the Coombe Women's Hospital *(continued)*

It is apparent that the dangers of smoking were clearly understood by women attending the hospital and that the dangers of alcohol were not.

Table 2 Percentage of pregnant women who stopped smoking during pregnancy, 2000 to 2005

	2000	2001	2002	2003	2004	2005
Stopped smoking during pregnancy	41.8	43.0	44.5	50.8	52.4	53.5

Table 3 Percentage of women who delivered a baby weighing less than 2,500 grams, by smoking status, 1999 to 2005

	Stopped smoking during pregnancy	5 or less cigarettes per day	6 to 10 cigarettes per day	11 to 20 cigarettes per day	21 or more cigarettes per day
Baby weighed less than 2,500 grams	3.4	6.0	8.5	9.6	13.1

Table 2 presents the increase between 2000 and 2005 in the proportion of women who stopped smoking during pregnancy. As the number of cigarettes smoked increased the likelihood of delivering a baby weighing less than 2,500 grams increased, indicating a direct and visible negative outcome associated with smoking (Table 3).

Overall, the reduction in consumption of alcohol, a potentially harmful substance, is very low and compares unfavourably with the increasing numbers of women who stopped smoking during their pregnancy (Table 2). It is apparent that the dangers of smoking were clearly understood by women attending the hospital and that the dangers of alcohol were not. This indicates a need to highlight the dangers of alcohol use for the foetus and for the child's long-term development. The major negative outcome of alcohol consumption during pregnancy is the development of foetal alcohol spectrum disorder, which comprises partial and complete foetal alcohol syndrome as well as alcohol-related neuro-development disorder. The latter disorder includes neuro-behavioural effects, which can develop from lower levels of alcohol consumption and manifest themselves in children and adolescents as attention and behavioural difficulties.

In total, 447 (1.0%) women reported using drugs associated with dependency during their pregnancy (Table 4). However, it is difficult to comment on these figures as it is not clear how many were using methadone or diazepam as a treatment rather than in an unregulated manner (street use). A higher proportion of women who reported drug use (16.6%) were likely to have a baby weighing less than 2,500 grams than the proportion of women who did not report drug use (5.1%).

According to the authors, the pertinent recommendations of the Strategic Task Force on Alcohol need to be implemented and substance use during pregnancy needs to be monitored. In addition, the authors recommend that a surveillance system be established to detect infants with foetal alcohol spectrum disorder. *(Jean Long)*

1. Barry S, Kearney A, Lawlor E, McNamee E and Barry J (2006) *The Coombe Women's Hospital study of alcohol, smoking and illicit drug use, 1988–2005*. Unpublished.

2. Strategic Task Force on Alcohol (2004) *Second report*. Dublin: Department of Health and Children.

Table 4 Drug use during pregnancy, 1999 to 2005 (43,318 women)

Drugs used	During pregnancy Number (%)
Yes	447
Type of drug used*	
Methadone†	323
Cannabis	87
Heroin	64
Diazepam†	51
Ecstasy	14
Cocaine	13

*The total number of drugs is greater than the total number of women as some women used more than one drug.
† These numbers do not discriminate between prescribed and street use.

Shared Solutions: First strategic plan of the Western Region Drugs Task Force

The first strategic plan of the Western Region Drugs Task Force (WRDTF), entitled *Shared Solutions*, was published this year (2006).[1]

The WRDTF was established in 2003. It covers counties Galway, Mayo and Roscommon (GMR). *Shared Solutions* incorporates the discussions of the WRDTF, local views expressed during two 'Open Space' consultation events held in November 2004, as well as information presented in a range of regional and national policy documents, research reports and other literature. The strategic plan takes the 'four pillars' of the National Drugs Strategy as its main themes: research; prevention and education; treatment; and supply reduction.

Despite the fact that Ireland's national alcohol and drugs strategies are managed separately, the WRDTF decided early on to include alcohol in its first strategic plan. The plan explains the reason for this decision: 'This decision reflects the reality that alcohol is the main problem drug nationally and regionally, and that the nature of substance misuse in our society does not necessarily follow lines neatly drawn by political, legal, social or institutional definitions.'

The strategic plan sets out a broad framework for integrated action and highlights the many inter-related issues to be addressed in the short, medium and long term. One of the broad aims of the strategic plan is to strengthen the protective factors that will assist communities, families and individuals to deal with substance use in the future.

Shared solutions

The shared solutions approach acknowledges that no one agency can tackle all drug-related problems on its own. However, joint planning and forward thinking may facilitate the development of shared solutions and integrated service planning that will address the drug and alcohol problem early and reduce the harmful impact of drug and alcohol misuse. This approach requires co-ordination, shared values and inter-agency co-operation.

The WRDTF intends to take a co-ordinating role in the development of projects specifically designed to prevent or tackle drug and alcohol misuse. 'The Task Force wants to work with agencies and communities in urban and rural areas to identify their own needs, develop their own plans and prioritise their own developments.' It intends to

Task Force staffing and setup

- Task Force co-ordinator
- Project worker
- Administrator
- Training budget
- Website development
- Accommodation

Measures to address gaps in services

- Four community liaison posts, in Galway city and county, Mayo and Roscommon, in order to link the social inclusion measures working group of each county development board.
- Three education support workers to support the implementation and ongoing delivery of the SPHE (Social, Personal and Health Education) programme and other community-based education programmes around substance misuse issues.
- Three nurses to provide community-based drug and alcohol detoxification, one for each county (GMR).
- Substance misuse worker for the homeless, who will develop a pilot project to engage with homeless people in the hostels and support projects.
- Pharmacy liaison worker to work with pharmacists, GPs and relevant agencies on the issue of misuse of benzodiazepines and other medicines. The pharmacy liaison worker will also offer training and support to pharmacists and work with them in relation to the development of a needle-exchange programme.
- Three community substance misuse brief intervention counsellors based in the third-level colleges (National University of Ireland, Galway and Galway Mayo Institute of Technology).
- Substance misuse consultant post
- Local inpatient detoxification beds to provide specialist inpatient alcohol and drug detoxification.
- Regional inpatient drug and alcohol treatment unit to replace the addiction treatment unit closed down in 2003.
- Funding to purchase rehabilitation places for drug and alcohol clients in existing programmes.
- Funding to develop a residential support service for homeless people.

Grants for

- community-based projects
- education, information and support for families affected by addiction
- primary prevention initiatives for young people

Research

- Substance misuse in the Traveller community
- Misuse of benzodiazepines and other medicines
- Service delivery for marginalised groups
- Evaluation of Task Force Implementation Plan

Shared solutions *(continued)*

integrate with existing structures, such as county development boards, social inclusion working groups, community forums and so on, in order to support these development plans.

The consultation process identified service gaps and other problems. The strategic plan includes an outline of proposed developments and their indicative costs. The proposed developments are grouped under four main themes: Task Force staffing and setup, measures to address gaps in services, grants and research (see table).

The consultation process and research review highlighted a number of key issues which require further analysis and consideration:

Protective factors – planning in order to reduce exposure to drug and alcohol misuse
Early intervention and treatment – providing early access to help or treatment
Rehabilitation and relapse prevention – maintaining a drug-free lifestyle
Relevance and need – projects must be drug or alcohol related, and directly relevant to the objectives of the regional and national drug strategies
Monitoring and evaluation – all projects will be subject to monitoring and evaluation criteria
Value for money – projects or initiatives must demonstrate value for money

The full complement of task force staff has now been appointed and the full-time co-ordinator is due to take up the post in the near future. This, along with the provision of appropriate funds, will enable the development and implementation of an operational plan. It is acknowledged that the practical work of the WRDTF is only beginning. Considerable effort and commitment is required in order to address the problems relating to substance misuse, and to develop and strengthen the inter-agency partnerships needed to make real progress. *(Sarah Fanagan)*

1. Western Region Drugs Task Force (2006) *Shared Solutions: First strategic plan of the Western Region Drugs Task Force*. Castlebar: Western Region Drugs Task Force.

Update on direct drug-related deaths in Ireland

Between 1990 and 1994, there was a small but steady increase in the number of drug-related deaths, and between 1995 and 1999 a substantial increase.

Problem drug use can lead to premature death. Deaths can occur as a result of overdose (both intentional and unintentional), actions taken under the influence of drugs, medical consequences and incidental causes. Drug-related deaths and mortality among drug users are indicators of the consequences of problem drug use in Ireland.

The data presented in this article provides the number of direct-drug-related deaths between 1980 and 2003, based on unpublished data from the Central Statistics Office (CSO). Direct drug-related deaths are those occurring as a result of overdose. At the European level, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has developed a standardised method for extracting data on drug-related deaths from the mortality registers in all member states.[1] Staff at the CSO[2] extracted and collated the data in April 2006, using the EMCDDA's 'Selection B' definition of drug-related death.

Figure 1 presents the numbers of direct-drug-related deaths in Ireland between 1980 and 2003, extracted from the General Mortality Register. There were few deaths in the eighties. Between 1990 and 1994, there was a small but steady increase in the number of drug-related deaths, and between 1995 and 1999 a substantial increase. This was followed by a considerable decline in the number of deaths between 2000 and 2002. In 2003, the number of drug-related deaths increased marginally when compared to 2001 and 2002.

Between 2001 and 2003, 60% of direct drug-related deaths were opiate-related.

Figure 2 presents the numbers of direct drug-related deaths in Dublin and in the rest of Ireland between 1980 and 2003.

According to data from the General Mortality Register, almost all direct drug-related deaths between 1980 and 1994 occurred in Dublin. Between 1995 and 1999, there was a substantial increase in drug-related deaths in Dublin, from 33 to 96; and there was a steady increase in drug-related deaths outside the Dublin area, from 3 to 26.

Between 2000 and 2003, there was a sharp decline in direct drug-related deaths in Dublin, from 83 in 2000 to 46 in 2003. This possibly reflects the decrease in new opiate users, the increase in methadone treatment places, the reduction in average waiting times for methadone treatment and the provision of methadone treatment in the Dublin prisons.

During this period there was a continued increase in drug-related deaths outside Dublin, from 30 in 2000 to 50 in 2003. In 2003, the number of drug-related deaths outside Dublin exceeded the number of drug-related deaths in Dublin for the

Update on drug-related deaths *(continued)*

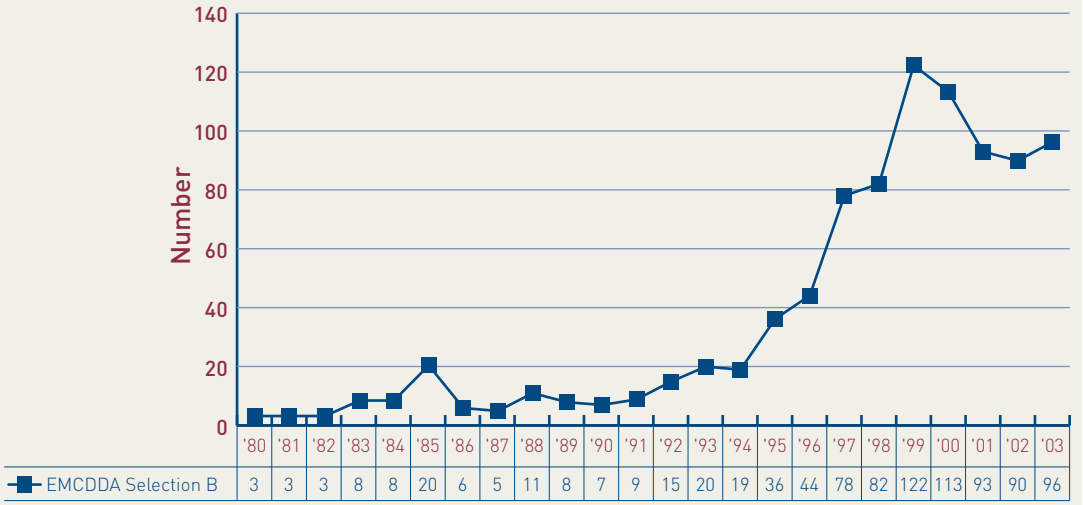


Figure 1 Number of direct drug-related deaths in Ireland reported by the CSO, 1980 to 2003 (unpublished data from the vital statistics)

The approach to opiate treatment in Dublin has been successful.

first time. The data for outside Dublin follow trends in problem opiate use in that geographical area.

The approach to opiate treatment in Dublin has been successful. It is likely that the introduction of opiate treatment in prisons and the reduction in average waiting times, in conjunction with the increase in methadone treatment places, have been key strategies in achieving this reduction. A similar approach to the management of problem opiate use is required outside Dublin. *(Jean Long, Ena Lynn and Lorraine Coleman)*

1. EMCDDA (2002) *The DRD-Standard, version 3.0: EMCDDA standard protocol for the EU Member States to collect data and report figures for the key indicator drug-related deaths by the standard Reitox tables.* EMCDDA project CT.02.P1.05. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

2. The authors would like to thank Joseph Keating at the Central Statistics Office for extracting and collating the data on direct drug-related deaths from the General Mortality Register.

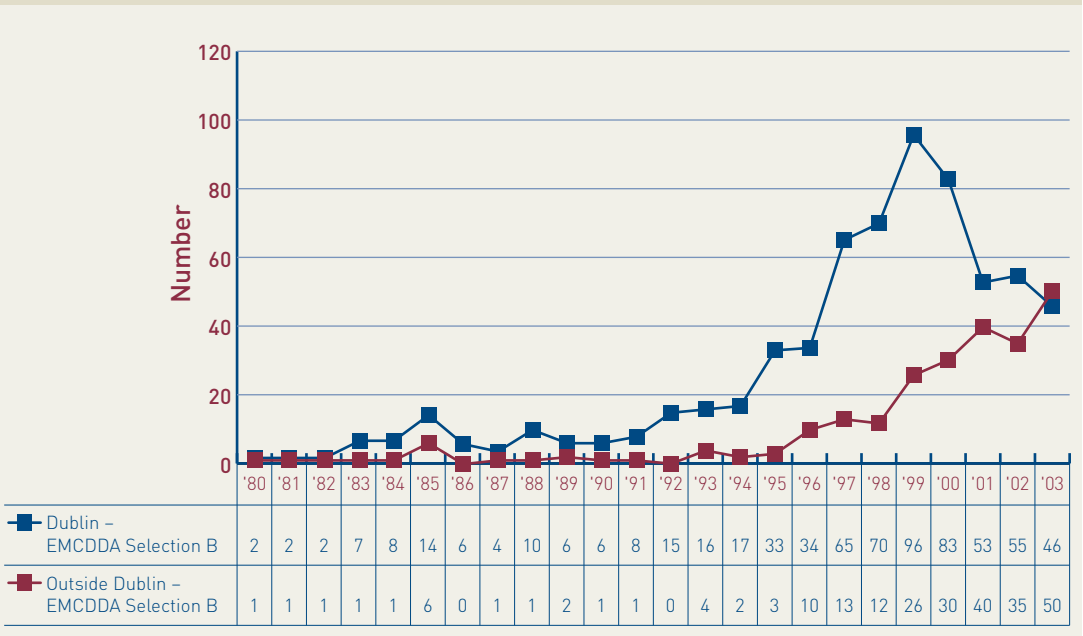


Figure 2 Number of direct drug-related deaths in Ireland, by place of death, reported by the CSO, 1980 to 2003 (unpublished data from the vital statistics

UN drugs policy under scrutiny

The first quarter of 2006 saw intense policy activity at international level. As UN drug bodies reported on the world drug control situation and considered policy options, international NGOs also offered their views.

A key event was the 49th Session of the Commission on Narcotic Drugs (CND), the central UN policy-making body dealing with drug-related matters, held in Vienna between 13 and 17 March.[1] The Session developed proposals to strengthen the international drug control system and to reduce the demand for drugs.

In respect of the control of drugs and precursors, the CND Session passed resolutions calling for, among other things:

- the use of alternative development programmes to reduce the cultivation of cannabis plants, especially in Africa
- stronger systems for the control of precursor chemicals used in the manufacture of synthetic drugs, including ecstasy, methamphetamine and amphetamine
- the listing of ketamine as a controlled substance by member states.

In Ireland ketamine is authorised as a prescription drug by the Irish Medicines Board. The Board states: 'If used on a daily basis for a few weeks, dependence and tolerance may develop, particularly in individuals with a history of drug abuse and dependence. Therefore the use of Ketamine should be closely supervised and it should be prescribed and administered with caution.'[2]

In response to the prevalence of HIV/AIDS and other blood-borne diseases among drug users, the CND Session passed a resolution calling for member states to:

- adopt actions based on studies and research that demonstrate the efficacy and efficiency of drug-related treatment and prevention;
- adopt drug-related health policies that facilitate prevention of drug abuse and access by drug users to different types of prevention, treatment and care for drug dependency, drug-related HIV/AIDS, hepatitis and other blood-borne diseases;
- enhance efforts to promote access to health and social care for drug users and their families without discrimination of any kind and, where appropriate, to co-operate with relevant non-governmental organisations;
- provide access, as appropriate and in the framework of the pertinent national policies, to medications, vaccines and other measures that are consistent with international drug control treaties and have been shown to be effective in reducing the risk of HIV/AIDS, hepatitis and other blood-borne diseases among injecting and other drug users, under the supervision of the competent authorities or institutions.

While noting that the CND resolution does not mention access to sterile injection equipment, the International Harm Reduction Association (IHRA) notes that it does refer to recent decisions of the Programme Coordinating Board (PCB) of the UNAIDS: 'This could be interpreted as an endorsement of the June 2005 global HIV prevention paper adopted at the PCB, which supported access to sterile injection equipment.'[3]

The CND Session held a thematic debate on alternative development (AD) as a drug control strategy. Most countries agreed that AD should integrate demand reduction, health and education and sustainable development efforts as well as crop eradication and law enforcement activities, and that it should be evaluated in terms not just of illicit crop reduction but also of social, economic and human development indicators.[1] In parallel with the CND Session, the Senlis Council, an international security and development think-tank, hosted the 7th International Symposium on Global Drug Policy: 'Bridging Security and Development'. The Senlis Council is critical of AD programmes, arguing that crop eradication has destroyed whole communities and been ineffective in lowering production. The Council is calling for licensing schemes that would allow farmers to cultivate crops such as opium for medical use.[4]

With regard to the world drug situation, the CND's deliberations were informed by the *World Drug Report 2005*, published in the weeks leading up the CND Session by the International Narcotics Control Board (INCB), the independent and quasi-judicial monitoring body for the implementation of the UN international drug control conventions.[5] The role of the INCB itself has come under close scrutiny. In February 2006 the Beckley Foundation Drug Policy Programme (BFDPP), a UK-based project dedicated to providing a rigorous, independent review of global drug policy, published a report exploring whether the INCB is 'watchdog' or 'guardian' of the UN drug control conventions. It argues that, by becoming guardian of the 'purity of the conventions' rather than watchdog, describing the situation and drawing attention to challenges and dilemmas, 'the Board undermines its own authority, and runs the risk of being seen as irrelevant to the shifting challenges faced by national governments and municipal authorities in responding to the widespread use of illegal drugs.'[6] On 1 March the Senlis Council announced its interest in the INCB, with the establishment of an expert panel to review its effectiveness. In anticipation of the upcoming review of global drug policy at the UN General Assembly Special Session

UN drugs policy *(continued)*

in 2008, the Panel will present a series of recommendations for reform of the INCB at the 2007 CND Session in Vienna.[4] *(Brigid Pike)*

1. Commission on Narcotic Drugs (2006) *Report on the forty-ninth session (8 December 2005 and 13–17 March 2006)* Economic and Social Council Official Records 2006, Supplement No. 8. (E/2006/28; E/CN.7/2006/10.) www.unodc.org/unodc/en/cnd.html

2. Irish Medicines Board 'Human Medicines: List of Human Authorised and Transfer Pending Products'. CRN 2021355, printed 24/3/2005. www.imb.ie

3. International Harm Reduction Association (2006) 'Commission on Narcotic Drugs – more support for harm reduction'. News Preview, 17 April 2006. Viewed 1 June 2006 at www.ihra.net

4. For further information on the Senlis Council, visit www.drug-policy.org

5. International Narcotics Control Board (2005) *Report of the International Narcotics Control Board for 2005* (E/INCB/2005/1) www.incb.org

6. Bewley-Taylor D and Trace M (2006) *The International Narcotics Control Board: Watchdog or Guardian of the UN Drug Control Conventions?* Report 7. Oxford: Beckley Foundation Drug Policy Programme, February 2006. Viewed 1 June 2006 at www.internationaldrugpolicy.net

From *Drugnet Europe*

Drug testing at work

Cited from Brendan Hughes Drugnet Europe *No. 54, April–June 2006*

Following discussion of the legal aspects of workplace drug testing at the legal correspondents meeting in September 2005, a new topic overview has been published on the European legal database on drugs (ELDD). This outlines international, European and national legislations on the subject. Workplace drug testing is a complex topic that is rarely regulated directly; much of the legal framework comes from interpretations of a combination of various laws, including those on labour codes, privacy, data protection, and health and safety at work. Nevertheless, new laws have recently been passed by Ireland, Finland and Norway to regulate the issue. Ireland reported that the legislation was welcomed by all parties, as it brought legal clarity to procedures that were already implemented by employers.

The topic overview is available at http://eldd.emcdda.europa.eu/?nnodeid=5036

E-POD: a case study of hallucinogenic mushrooms

Cited from Jennifer Hillebrand, Deborah Olszewski and Roumen Sedefov Drugnet Europe *No. 54, April–June 2006*

The EMCDDA is in the process of developing a pilot project, E-POD (European Perspectives on Drugs), to explore to explore the capacity in EU Member States to detect, track and understand emerging drug trends using methods that depend on the triangulation of a wide range of different sources to assess the veracity of accumulated information.

The E-POD project follows the European Trend project and utilises data made available by the early warning system on new drugs and the Reitox network. It will contribute to the implementation of the EU drugs action plan (2005–2008) objective: to 'develop clear information on emerging trends and patterns of drug use and drug markets', provide better understanding of the drugs phenomenon and thereby help with the development of responses.

New EMCDDA website address

Since 9 May 2006, the EMCDDA's website address has changed to www.emcdda.europa.eu. The old website address (www.emcdda.eu.int) will continue to work until May 2007, with traffic being automatically redirected to the new domain name when necessary during this interim period.

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). An electronic version of *Drugnet Europe* is available on the EMCDDA website at www.emcdda.europa.eu

If you would like to receive a hard copy of the current or future issues of *Drugnet Europe*, please contact Charlene Lydon, Drug Misuse Research Division, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2. Tel: 01 676 1176 ext 127; Email: dmrd@hrb.ie

The EDDRA column

Staff from SIRUS, the Norwegian EMCDDA focal point, on a visit to the DMRD. *L to r:* Mr Anders Bryhni, Dr Hamish Sinclair (DMRD), Mr Odd Hordvin and Ms Hege Lauritzen (EDDRA Manager, SIRUS)

Copping On National Crime Awareness Initiative

Welcome to the fifteenth EDDRA (Exchange on Drug Demand Reduction Action) column. The aim of this column is to inform people about the EDDRA online database, which provides information on good practice interventions to policy makers and those working in the drugs area across Europe, and to promote the role of evaluation in reducing demand for drugs. The database is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

This article will look at the findings from a recent evaluation of the Copping On National Crime Awareness Initiative.[1] This initiative has been included on the EDDRA database as an example of good practice in working with young people at risk. An important requirement of good practice is a willingness to evaluate and improve an intervention by developing a focused and strategic plan. The evaluation of Copping On was commissioned to assist in the development of a strategic plan.

The Copping On National Crime Awareness Initiative is now celebrating its tenth anniversary. The initiative was established to provide crime prevention and awareness training to groups working with young people at risk, such as members of the Probation and Welfare Service, the Garda, and youth workers. The City of Dublin Vocational Educational Committee (CDVEC) administers the programme and the Department of Education, the Department of Justice and FÁS provide funding. The two-day training course delivered to participating groups covers communications, relationships, drugs and alcohol, decision making and the role of the justice system in society – all relevant issues in the lives of the young people that these groups work with. Junior and senior resource packs are provided to enable participants to structure their work with at-risk young people around the central themes of the initiative.

The evaluators sought the views of a small number of young people who received training from trained facilitators based on the Copping On material. Of the sessions delivered to the young people, those that had most impact were the prison visit, drug and alcohol awareness and discussion on stereotyping. Overall, it appeared that the young participants gained a better understanding of the consequences of choices they made.

The evaluation also surveyed 420 programme participants, of whom 91 (22%) responded. Some key findings from this survey were:

- 57% of respondents felt that the training was highly or very useful, and 40% gave it a rating between very low and medium usefulness.
- 46% used the training for crime prevention purposes only, and 53% for other purposes.
- Respondents reported using Copping On material with approximately 1,250 young people.
- 57% agreed that the current programme content fitted their needs.
- 61% would like Copping On to develop a DVD for crime awareness work with young people; 57% would like training on re-offending; 49% would like training and resources to assist in work with young people with low literacy levels; and 48% would favour greater focus on work with the families of young people at risk.
- 78% had used the resource packs and reported them to be user friendly.
- 78% had not attended follow-up training.
- 41% believed that the Copping On initiative had changed their approach to crime awareness work with young people.

The evaluation contains a number of key recommendations designed to improve the strategic focus and location of Copping On, build on and develop its evaluation culture and develop its capacity to respond to the changing needs of the main target groups. Two specific recommendations are:

- Training should expand to focus on young people with low literacy levels, families of young people at risk and those at risk of re-offending.
- Copping On should expand and update its data-collection system to include information on levels of participant delivery of programmes to young people, the impact of the programme on young people, follow-up training and project visits and how the programme can continue to meet the needs of the target groups.

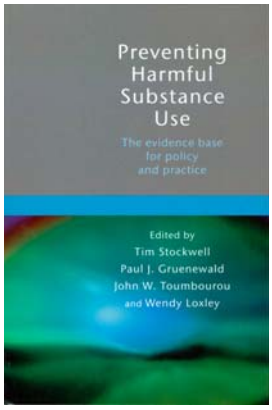
A copy of the evaluation is available in the publications section of the Copping On website at www.coppingon.ie *(Martin Keane)*

1. Duffy A (2005) *Evaluation Report: Copping On 2000–2004*. Dublin: Copping On National Crime Awareness Initiative.

If you have an intervention that has been evaluated and you wish to highlight your work and share the information from your evaluation with a national and international audience, please contact Martin Keane, EDDRA Manager, at 01 6761176 ext 169 or Email: mkeane@hrb.ie

The National Documentation Centre on Drug Use

In Issue 16 of *Drugnet Ireland* we looked briefly at the concept of evidence-based medicine (EBM). This article will examine some of the issues around finding reliable evidence on substance use treatment and prevention and will review some of the recent literature on this subject.



EBM and addiction

Reimer[1] points out that the efficacy of the evidence-based approach to clinical practice is by no means universally accepted. Criticism focuses on the narrow range of reliable research methods accepted by the approach and difficulties in interpreting and applying the results of meta-analysis and systematic reviews. The fields of substance use treatment and prevention are not immune to the debates surrounding the appropriateness of EBM. However, a number of factors not directly related to the application of evidence-based treatments in the clinical setting have contributed to EBM's increasing relevance in the addictions field. Reimer identifies these factors as:

- an increasing emphasis on accountability and evidence of effectiveness from governments and funding agencies, particularly since the early 1990s
- the importance to healthcare policy of standardised treatment procedures, cost-effectiveness and outcomes
- the recognition, by those delivering services in the community, of the importance of delivering empirically supported therapies as funding sources increasingly emphasise best-practice guidelines.

Despite this supportive environment, the body of evidence available to practitioners wishing to pursue an evidence-based approach to treatment and prevention is small. Lacroix[2] explains that the dominance of the disease model of addiction meant that the introduction of non-medical therapies occurred relatively recently. Addiction medicine developed rapidly as a separate discipline in the US in the immediate post-war period. But it was not until the 1980s that a more complex understanding of the nature of addiction emerged and psychologists and counsellors began to apply different models of treatment. Therefore, the study of addiction has not yet produced a body of evidence-based knowledge comparable with that of other branches of medicine and health science.

Sources of evidence

The number of systematic reviews and practice guidelines developed for non-medical treatments is very small. The Cochrane Database of Systematic Reviews is divided into a number of thematic review groups. The Drug and Alcohol Group and the Tobacco Addiction Group are the review groups of most interest to those studying addiction treatments. Of a total of 31 completed systematic reviews published in the current issue (2, 2006) by the Drug and Alcohol Group, only seven dealt primarily with psychosocial or other non-pharmaco-therapy interventions. There were no such reviews in Issue 4, 2001, so interest is increasing. However, in many of the recent studies the outcome was inconclusive because of inadequate or incomplete research.

The *Medline* database is the main source of bibliographic information on medical literature and it is possible to select literature for evidence-based decision making from it. By limiting publication types to meta-analysis, practice guidelines or randomised controlled trials, it is possible to estimate the volume of literature dealing with evidence-based approaches to treatment for addiction and substance use disorders. Only about 2% of the total number of articles in this category deals primarily with non-medical or psychosocial interventions. It would be necessary to consult a

Students from An Cosán educational project in Tallaght who are studying for a Diploma in Community Drugs Work in UCD with Dr Aileen O'Gorman, UCD, and Ms Anne O'Keefe, An Cosán, on a visit to the National Documentation Centre.

National Documentation Centre *(continued)*

number of sources to carry out a useful literature review in this area. Other databases which might produce relevant material include *PsycINFO*, the database of the American Psychological Association; *ETOH*, the *Alcohol and Alcohol Problems Science Database* (not updated since 2004 but still a valuable source of literature in this area); and *DrugData*, maintained by the library of DrugScope in the UK.

Several medical organisations in the US publish practice guidelines on substance use treatment, many of which are available online through the National Guidelines Clearing House database (www.guidelines.gov). Finney[3] explains the difficulty in developing comprehensive, useful practice guidelines for behavioural and psychosocial approaches to treatment. Such guidelines do exist, but they are not as easy to locate as medical guidelines. Finding appropriate ones may involve a detailed literature search and an examination of the publications produced by relevant research centres and well-known researchers in the field.

Recent publications

A number of recent publications reviewing literature in the addiction field are useful for identifying high-quality research. Stockwell *et al.*[4] provide a summary of recent research on aspects of prevention work and assess the effectiveness of various intervention strategies described in the available research. Lingford-Hughes *et al.*[5] wrote a very useful review of recent research on pharmacological management of problem drug use. They argue that, while quality research is scarce, a wealth of clinical experience can be drawn on to increase the effectiveness of treatment. In an American study, McGovern *et al.*[6] examine the process by which treatment professionals use an evidence-based approach to select appropriate interventions.

Research transfer

Summarising the literature on the research-to-practice exchange, Reimer[1] identifies three prerequisites for effective research transfer:

- relationships need to be developed between researchers, practitioners and policy makers
- research evidence and practice guidelines must be combined with individual instruction, incentives and active learning strategies
- research organisations need to devote an equal amount of funding to research studies and to research transfer

Research on addiction and substance use cannot, of course, match that in the medical field in terms of funding or infrastructural support. Researchers and information professionals have an important role in drawing attention to the evidence that does exist and ensuring that it is used to establish a sound evidence base for programmes and policy in the field. *(Brian Galvin)*

1. Reimer B (2003) *Strengthening evidence-based addictions programs: a policy discussion paper*. Ottawa: Canadian Centre on Substance Abuse. www.ccsa.ca/pdf/ccsa-010214-2003.pdf

2. Lacroix SI (2002) Evidence-based and best-practice addiction treatment resources: a primer for librarians. *Behavioral & Social Sciences Librarian*, 21(1): 61–71.

3. Finney JW (2000) Limitations in using existing alcohol treatment trials to develop practice guidelines. *Addiction*, 95(10): 1491–1500.

4. Stockwell T, Gruenewald P J, Toumbourou J W and Loxley W (eds) (2005) *Preventing harmful substance use: the evidence base for policy and practice*. Chichester: John Wiley.

5. Lingford-Hughes AR, Welch S and Nutt DJ (2004) Evidence-based guidelines for the pharmacological management of substance misuse, addiction and comorbidity: recommendations from the British Association for Psychopharmacology. *Journal of Psychopharmacology*, 18(3): 293–335.

6. McGovern MP, Fox TS, Xie H and Drake RE (2006) A survey of clinical practices and readiness to adopt evidence-based practices: dissemination research in an addiction treatment system. *Journal of Substance Abuse Treatment*, 26(4): 305–312.

The National Documentation Centre will be closed to visitors from Monday 31 July 2006 and will reopen on Tuesday 8 August. During this time, NDC staff will continue to take telephone and email queries.

In brief

On 1 February 2006 the **Courts Service** announced that the **Drugs Treatment Court** is to be put on a permanent footing and extended on a staged basis to all court areas in the Dublin Metropolitan District. www.courts.ie

On 2 February 2006 ***Drugs and Doping in Sport: Guidelines for General Practitioners*** was published by the Irish Sports Council and the Irish College of General Practitioners. www.icgp.ie / www.irishsportscouncil.ie

On 6 February 2006 the **Homeless Agency** launched ***Preventing Homelessness: A Comprehensive Preventative Strategy to Prevent Homelessness in Dublin, 2005-2010***. The Strategy acknowledges that drug, alcohol, mental health or other personal and health problems may lead individuals into homelessness. www.homelessagency.ie

On 13 February 2006 the **Customs Service** launched its mobile x-ray scanner. Speaking at the launch, Minister Noel Ahern TD said the scanner would assist in the disruption of the flow of drugs into the State. www.pobail.ie

On 13 February 2006 the **SDLP** published ***North South Makes Sense***. Under the heading of health and social services, the document proposes 'shared provision of specialised units and services for young people with drug/alcohol addiction'. In relation to justice and policing, it calls for a North/South Criminal Justice Treaty and an all-Ireland Criminal Assets Bureau, Law Commission and Intelligence Agency. www.sdlp.ie

On 17 February 2006 the **Financial Action Task Force (FATF)**, an inter-governmental body whose purpose is the development and promotion of national and international policies to combat money laundering and terrorist financing, published its assessment of the implementation of its anti-money-laundering and counter-terrorist-financing standards in Ireland. It reported that Ireland has a sound legal framework in place to combat money laundering, although the number of convictions for money laundering is 'somewhat low'. www.fatf-gafi.org

In February 2006 the **Dublin Simon Tenancy Sustainment Service** was announced. Intended to break the cycle of homelessness, the service will prioritise people and families moving out of homelessness into tenancies, as well as working with people who are in established tenancies but who are at high risk of the tenancies breaking down and thus returning to homelessness. www.dubsimon.ie

On 7–8 March 2006 the **National Roads Authority** held a conference on road safety. Three papers were presented relating to driving under the influence of alcohol or drugs, including one on 'Eye Testing for Drugs and Driving'. www.nra.ie

On 14 March 2006 the report S***chool Matters – The Report of the Task Force on Student Behaviour in Second Level Schools*** was published. Two societal factors identified as directly affecting schools and the behaviour of students, and leading in some situations to dysfunctional behaviours in schools, were '*youth culture*', which includes clothes, hairstyles, sexuality, music, technologies and language 'and, for some, experimentation with alcohol and drugs', and '*lifestyle*', and in particular young people's patterns of drinking. www.education.ie

On 29 March 2006 the **Rainbow Project** launched a research report ***Out on your Own***, examining the mental health of young same-sex-attracted men in Northern Ireland. The researchers found that 71.6 per cent of respondents had tried drugs or solvents at least once. This finding mirrors international research showing that lesbian, gay and bisexual (LGB) people are more likely to use recreational drugs than heterosexual people. www.rainbow-project.org

In March 2006 the ***Report of the High Level Group on Traveller Issues*** was published by the Department of Justice, Equality and Law Reform. The report summarises the current situation and makes recommendations with regard to the provision of services to Travellers in the areas of accommodation, health, education and employment. The Group noted that in 2005 three local drugs task forces (Bray, Dublin North-East, and South Inner City) were funding projects specifically targeted towards Travellers. It also noted that the National Advisory Committee on Drugs has commissioned an exploratory study of drug use and drug issues among the Traveller community. www.justice.ie

In March 2006 the **Department of Justice, Equality and Law Reform** undertook a nationwide survey of public attitudes towards crime and law enforcement issues in Ireland. The survey revealed high levels of concern regarding most of the crimes listed, with 'drug abuse' being almost universally seen as the most serious problem. www.justice.ie

On 5 April 2006 the **Irish Sports Council** launched its ***2005 Anti-Doping Annual Report***. It reports that in 2005, 962 tests were carried out. There were two positive findings, for cannabinoids, one in squash and one in rugby. Sanctions were imposed. www.irishsportscouncil.ie

On 18 April 2006 the **Task Force on Active Citizenship** was announced by the Taoiseach, Bertie Ahern TD. The Task Force is due to report in nine months' time with recommendations for facilitating and encouraging a greater degree of engagement by citizens in all aspects of life and the growth and development of voluntary organisations as part of a strong civic culture. www.taoiseach.gov.ie

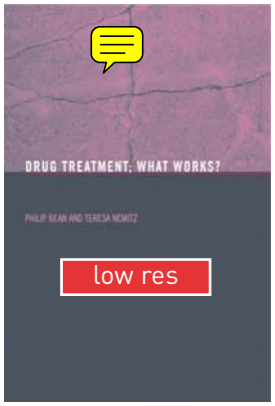
On 26 April 2006 the **Drugs Awareness Programme**, with sponsorship from the Vodafone Ireland Foundation, launched a new mobile phone text-alert service to provide people with urgent advice on the dangers of illicit drugs. www.dap.ie

In April 2006 the **Irish Society for the Prevention of Cruelty to Children (ISPCC)** released its Childline Annual Call Statistics 2005. These figures show that 1,104 (0.94%) calls were on the subject of substance use; 361 (0.31%) on alcohol use; and 240 (0.20%) on smoking. In the wake of the launch of the statistics, the ISPCC called for the establishment of a new Life Skills Education Programme in primary schools and the introduction of a nationwide parent support programme. It claimed that there is growing evidence that drink and drugs, mobile phone usage, Internet usage, sexual pressures and mental health are major factors for children as young as eleven and twelve. www.ispcc.ie

(Compiled by Brigid Pike)

Recent publications

Books



Drug treatment: What works?

Bean P and Nemitz T (eds)
Routledge 2004, 272 pp.
ISBN 0 415 26817 6

Finding ways of dealing with the burgeoning drug problem is a major platform of UK government policy and a great deal has been made of the impact of treatment on drug users. *Drug treatment: What works?* deals with the nature of treatment and surveys some of the latest developments and problems associated with providing treatment to substance misusers, as well as concentrating on criminal justice issues.

Behind the slogan 'Treatment works' lies a range of difficult questions; many are rarely asked and most produce no easy answers. According to the authors, these questions demand evaluation of the way the treatment agencies operate. By implication, they introduce pertinent questions about the distribution and location of services, and demand an examination of current practices. This book sets out to address some of these questions, including:

- Which treatments work with what sorts of abusers?
- What are the key indicators of likely success?
- Does coercion work, or must treatment be freely entered into?
- Is drug testing an essential backup for successful treatment?

Featuring contributions from some of the leading figures in this field, this book will be of value to students, academics and professionals studying drug treatment in the areas of criminology, social policy and medicine. Philip Bean is an Emeritus Professor of Criminology and former director of the Midland Centre for Criminology and Criminal Justice at Loughborough University. Teresa Nemitz is a researcher at Loughborough University.

Using women

Roberts M and Vromen N
DrugScope 2005, 71 pp.

The Using Women Campaign was developed by DrugScope, the UK's leading independent centre of expertise on drugs and drug policy, and is specifically concerned with women who get into trouble because of illegal drugs. There was an increase of 173 per cent in the average number of females in custody in between 1992 and 2002. In 2002, 44 per cent of the adult female prison population were in prison for drug offences. The campaign believes that a substantial reduction in the number of women in prison for drug and drug-related offences is both desirable and achievable.

The opening section of this report gives facts and figures about women in prison in the UK. It outlines some recent improvements in referral and treatment processes for drug-using women and suggests ways of dealing with the growth in the female prison population.

The remainder of the report examines the key issues in detail – providing a platform for the voices of ex-prisoners and professionals who have spoken to Using Women. The next four chapters are concerned with the link between drugs and crime, the experiences of women in the prison system, the impact on children and alternatives to prison. A final chapter draws out the policy messages and sets out a 12-step reform programme.

Report of the International Narcotics Control Board for 2005

United Nations 2006, 112 pp.
ISBN 92 1 148209 7

As the International Narcotics Control Board demonstrated in its annual report for 2004, the fundamental interaction between the supply of and demand for drugs is anything but straightforward. The same applies to alternative development, which the Board has chosen to examine in the first chapter of its report for this year. The report observes that there are substantial limitations in alternative development approaches taken in the past, and the concept needs to be broadened in order to achieve large-scale, sustainable results. The issue of legitimate alternative livelihoods needs support in both rural and urban areas where illicit drugs are abused, instead of addressing only rural areas where illicit drug crops are cultivated.

The second and third chapters follow the format of previous reports. Chapter II, Operation of the international drug control system, describes the current status of adherence to the Single Convention of 1961 and levels of co-operation with the control system by member States in relation to narcotic drugs, psychotropic substances, precursors and special topics. Chapter III, Analysis of the world situation, covers the five continents in terms of major developments; treaty adherence; regional co-operation; national legislation, policy and action; cultivation, production, manufacture, trafficking and abuse; and missions from the Board to selected countries.

A new chapter introduced in this 2005 report is titled 'Recommendations to Governments, the United Nations and other relevant international and regional organizations'. This chapter selects for special emphasis some of the key recommendations and proposals for further action contained in earlier chapters.

Recent publications *(continued)*

Journal articles

The following abstracts are from a selection of articles relating to the drugs situation in Ireland recently published in international journals.

Blood alcohol levels in persons who died from accidents and suicide

Bedford D, O'Farrell A and Howell F
Irish Medical Journal 2006; 99(3): 80–83

This study reviewed coroners' records to identify blood alcohol concentrations of 129 persons who died as a result of injury or suicide in three counties in 2001 and 2002. Of these, 98 (76%) were male, 55 (43%) were road traffic accidents (RTAs), 31 (24%) were suicides, 12 (9%) misused substances, 11 (8.5%) were in house fires and 20 (15.5%) were due to other causes.

Of the 55 who died as a result of RTAs, 22 (40%) had positive blood alcohol concentrations, ranging from 16mg per 100ml to 325mg per 100ml. Of the 31 who died as a result of suicide, 28 (90%) were male and blood alcohol concentrations were available for 29 (94%) persons. Of these, 16 (56%) had alcohol detected. Persons aged less than 30 years were more likely to have alcohol in their blood ($p<0.002$). The mean blood alcohol concentration for persons aged less than 30 was 192mg per 100ml, compared to 84mg per 100ml for those aged 30 and over. The mean blood alcohol concentration for adults who died in house fires was 225mg per 100ml. Of the 12 who had a record of substance misuse, 11 had blood alcohol concentrations completed and six had a blood alcohol level greater than 79mg per 100ml, indicating a link between alcohol and drug use. The high blood alcohol concentrations in those who died as a result of suicide or injury reflect the high level of alcohol consumption and binge drinking in Ireland.

Providing health education on accidental drug overdose

Branagan O and Grogan L
Nursing Times 2006; 102(6): 32–3

There is an association between intravenous drug use and increased risk of death due to overdose. This article reports the results of an evaluation of a health promotion programme to educate drug users on how to prevent and how to deal with an overdose. The health promotion intervention consisted of a poster and leaflet. A convenience sampling method was employed and 20% of service users attending 15 drug treatment clinics were asked to complete the questionnaire. In total, 200 questionnaires were distributed; 194 (97%) were completed. Of the 194 respondents, 81% had read the poster and 78% recalled a useful message from the poster. Over 70% reported that they changed the way they thought about or dealt with an overdose. One-fifth of the respondents suggested improvements to the poster and leaflet. This nurse-led intervention had an important and positive impact on service users.

Drug-related mortality and its impact on adult mortality in eight European countries

Bargagli AM, Hickman M, Davoli M, Perucci CA, Schifano P, Buster M, Brugal T and Vicente J
European Journal of Public Health 2006; 16(2): 198–202

The objective of this study was to estimate the mortality rates from drug-related deaths and other causes among problem drug users and population attributable risk of death due to opiate use in eight study sites in Europe. Opiate users were recruited from drug treatment centres during the period 1990–1998 and deaths followed up through national or local mortality registries. Gender-specific overall mortality rate, proportion of deaths by cause (drug-related, HIV, other), standardized mortality ratios (SMRs), and the attributable risk fraction (ARF) were estimated. Crude mortality rates varied from 1 per 100 person-years in the Dublin and London cohorts to 3.8 per 100 person-years in Barcelona. The highest drug-related mortality rate was 10 per 1000 person-years in Barcelona; the rates were similar to 7 per 1000 person-years in Denmark, London, Rome, and Vienna, and < 3.5 per 1000 person-years for the others cohorts. The mortality rate for AIDS was < 2 per 1000 person-years in all the cohorts except Lisbon, Rome, and Barcelona, for which it was similar to 6 per 1000 person-years. The highest SMR among males was 21.1 in Barcelona, and among females the highest SMRs were 53.7 and 37.7 in Barcelona and Rome, respectively. In Denmark the ARF was 5%, whereas it was > 10% in all other study sites and 24% in Barcelona. Cohort mortality studies, especially in combination with estimates of prevalence, provide useful insights into the impact of opiate use on mortality across European countries and emphasize how preventing overall and drug-related deaths among opiate users can significantly improve the health of the population.

Responses to positive and negative smoking-related images: effects of current smoking status and degree of smoking addiction

van Hanswijck de Jonge L and Gormley M
Addictive Behaviors 2005; 30(8): 1587–91

The literature indicates that stimulant users of various dependency levels endorse and react differently to stimuli that portray the stimulant either positively or negatively; however, these studies have not been extended to smoking. Here, pictures are used to depict either positive or negative connotations of smoking. The current study concentrated on smokers with different levels of dependency. Seventy-three digital images were rated on both a smoking and emotional content scale. The pictures were rank ordered, yielding the 10 most positive and negative smoking-related pictures. Emotional content scores for these pictures

Recent publications *(continued)*

were also recorded. Data from 148 subjects [light- (n=28), heavy- (n=17), ex- (n=32) and never-smokers (n=71)] were analysed. Using a mixed factorial ANOVA light and heavy smokers were found to score positive pictures significantly more positive than the never-smokers, they did not vary on negative or emotional ratings. Thus positive pictures did not distinguish heavy and light levels of substance use as suggested by the literature and this was not influenced by emotional content.

Psychiatric morbidity in a cross-sectional sample of male remanded prisoners

Linehan SA, Duffy DM, Wright B, Curtin K, Monks S and Kennedy HG
Irish Journal of Psychological Medicine 2005; 22(4): 128–132

The objective of this study was to estimate the psychiatric service requirements of the remand population. The authors interviewed 232 (42.6%) men, a representative sample of men on remand, using the SADS-L, SODQ and a structured demographic interview. High rates of psychiatric morbidity were found in the sample. The six-month prevalence of psychosis was 7.6%, almost twice the rate in a recent international meta-analysis. Major depressive disorder was present in 10.1% (six month prevalence). Substance misuse problems were also common but there was no significant difference between rates of substance misuse in psychotic and non-psychotic prisoners. A total of 31.2% had a lifetime history of any mental illness (excluding substance misuse, adjustment disorder and personality disorder). The high levels of psychiatric morbidity detected in the sample indicate a substantial unmet need for mental health services and addiction treatment services for the mentally ill in Irish prisons.

Psychiatric problems in children exposed to opiates in utero

Clarke C and Fitzpatrick C
Irish Journal of Psychological Medicine 2005; 22(4): 121–123

The objective of this study was to describe the psychosocial and clinical characteristics of children referred to a community-based child and adolescent mental health service, whose mothers reported that they took opiates during the pregnancy. In a retrospective study, the case notes of all children whose mothers reported that they had been exposed to opiates in utero, and who were referred to the Department of Child and Family Psychiatry, Mater Hospital, between 2001 and 2003, were identified by maternal reports. Information was obtained on age, gender, referral source, socio-economic group, family type, number of siblings, involvement of community care services, nature of presenting problems, diagnosis, interventions offered, and treatment difficulties. Information was recorded anonymously.

Fifteen children were identified, of whom nine were male. Most were found to be living with their mother alone or with their mother and a partner, and to be socially and financially disadvantaged. Their presenting complaints usually involved combinations of aggressive, hyperactive, and oppositional behaviour. Diagnoses included ADHD, a speech and language disorder, and an axis II disorder. Interventions were frequently unsuccessful because of parents' difficulties with attending appointments and because of instability in the families' living arrangements. The authors conclude that these children, due to a complex interplay of biological and psychosocial adversity, are at serious risk of ongoing psychiatric disorders in childhood and adolescence and for adverse outcomes in adult life. A prospective cohort study of all children born to opiate-dependent mothers is necessary to quantify the level of risk and identify resilience factors.

The point-prevalence of alcohol use disorders and binge drinking in an Irish general hospital

Molyneux GJ, Elizabeth C and Dooley E
Irish Journal of Psychological Medicine 2006; 23(1): 17–20

There is a paucity of data concerning the prevalence of alcohol use disorders and binge drinking in the general hospital adult population in Ireland. The authors examined the point-prevalence of alcohol use disorders and of binge drinking in the adult inpatient population of the acute wards of an Irish university teaching hospital. The secondary aim was to examine gender, age, and patient group (medical/surgical) as risk factors. The authors administered the Alcohol Use Disorders Identification Test (AUDIT) to all consenting patients (n=126) on the acute adult medical and surgical wards over one day.

76% of all inpatients on the acute medical and surgical wards were interviewed (n=126) using the AUDIT. Of the subjects, 28% screened positive for an alcohol use disorder, of whom 91% were identified as binge drinkers. A further 8% of the subjects screened positive for binge drinking but were not identified as having an alcohol use disorder. Overall, 36% of the subjects screened positive for either an alcohol use disorder and/or for binge drinking using the AUDIT. Being male and aged under 65 were risk factors for both alcohol use disorders and binge drinking.

The high point-prevalences of alcohol use disorders and binge drinking in hospital inpatients in particular are a cause for concern as they may have illness complicated by or secondary to undiagnosed alcohol excess. As this population is an easily accessible group for screening, and clinical and economic evidence supports intervention, we recommend screening all acute hospital admissions for alcohol use disorders and binge drinking, followed by appropriate management.

(Compiled by Joan Moore and Louise Farragher)

Upcoming events

(Compiled by Louise Farragher) **Email: lfarragher@hrb.ie**

June

28 June 2006
Treatment effectiveness: how to deliver
Venue: Mermaid Conference Centre, London
Organised by/Contact: National Treatment Agency
www.nta.nhs.uk

Information: The conference aims to provide practical guidance, advice and best practice on delivering treatment which improves adult clients' journeys into, through and beyond treatment.

July

6–8 July 2006
The European Association of Addiction Therapy (EAAT)
Venue: Central Hall Westminster, London
Organised by/Contact: EAAT Scientific Secretariat
Tel: +44 (0)115 969 2016
Fax: +44 (0)115 969 2017
www.eaat.org

Information: The European Association of Addiction Therapies (EAAT) provides a focus for understanding the scientific and social bases of addiction and discusses relevant therapies throughout Europe. Through the annual conference, working with the journal *European Addiction Research*, and international collaborative ventures, the EAAT aims to improve the understanding, treatment and management of addictive behaviours. The conference topics and sessions are as follows:
Session 1: Genetics, Aetiology, Epidemiology, Neuroimaging and Underlying Neuronal Mechanisms
Session 2: Treating the clinical consequences 1: Alcoholism
Session 3: Treating the clinical consequences 2: Drug dependence
Session 4: Nicotine, society and the accepted addictions
Session 5: Dual diagnosis
Session 6: Late breaking news, Case studies, Culture and history

September

3–7 September 2006
What makes good practice—49th International Council on Alcohol and Addictions (ICAA) Conference on Dependencies
Venue: Assembly Hall, Edinburgh
Organised by/Contact: International Council on Alcohol and Addictions
www.icaa-uk.org

Information: The conference will provide a broad platform of dialogue and enlightenment for professionals in the fields of substance-abuse prevention, treatment, research and policymaking. In a multidisciplinary setting, experiences on the grassroots level will encounter latest research findings and tie the many strands together. It will also feature professional visits and special-interest seminars on 8 September 2006. Local and International Organising Committees have started planning ICAA's major event of 2006, which will allow a comprehensive approach representing opinions of various fields in different forms of sharing knowledge – while still exploring commonalitites for future building of plans.

18 September 2006
The Drug Treatment Centre Board 2006 Autumn Educational Seminars
Venue: Newgrange Hotel, Navan, Co Meath
Organised by/Contact: Drug Treatment Centre Board
Tel: + 353 (01) 6488600
www.addictionireland.ie/events

Information: Following on from the success of the 2005 Educational Events in Galway, Limerick and Cork, The Drug Treatment Centre Board will present a series of seminars in Meath, Donegal and Kilkenny. With a range of speakers including Dr Brion Sweeney, Dr Bobby Smyth, Dr Joe Barry, Dr Declan Bedford and Dr Des Corrigan, the programme will address issues such as the 4 Tier Model, Development of Adolescent Services, Drugs and Alcohol and the Effects of Psychoactive Drugs. Mindful of the opinions of delegates at previous events, we have included in the programme a workshop component that will present case studies and design care plans in a multidisciplinary manner. This one-day seminar costs 140.00 per person, with a 10% discount for parties of three or more booking together. The cost includes copies of the speakers' papers, refreshments and lunch.

October

4 October
The Drug Treatment Centre Board 2006 Autumn Educational Seminars
Venue: Mill Park Hotel, Donegal Town, Co Donegal
Organised by/Contact: Drug Treatment Centre Board
Tel: + 353 (01) 6488600
www.addictionireland.ie/events

12–13 October 2006
National Conference on Injecting Drug Use
Venue: Lord's Cricket Ground, London
Organised by/Contact: Exchange Supplies
Tel: +44 (0)1305 262244
www.exchangesupplies.org

Information: The full programme will contain over 30 plenary and parallel sessions designed to inform practice, explore policy and develop skills.

Key conference themes:
- 20 years of needle exchange: evaluating progress, identifying priorities

Upcoming events *(continued)*

- prisons: viral transmission and needle exchange
- femoral injecting
- snowballing and non-opiate injecting
- HIV – what do the figures mean?
- hepatitis C
- wound care

Call for papers: Papers and ideas for presentations are welcomed. Submissions may be accepted for either oral paper presentations or poster displays. All submissions will be peer reviewed and judged on their relevance to the conference. The deadline for submissions is 1 August 2006.

17 October 2006

The Drug Treatment Centre Board 2006 Autumn Educational Seminars

Venue: Kilkenny River Court, Kilkenny
Organised by/Contact: Drug Treatment Centre Board
Tel: + 353 (01) 6488600
www.addictionireland.ie/events

November

7 November 2006

Hepatitis C: Action for prevention, treatment and management

Venue: Royal College of Surgeons, London
Organised by/Conatct: KCA, 43a Windmill STreet, Gravesend, Kent DA12 1BA, UK.
Tel: +44 (0)1474 326168
Fax: +44 (0)1474 325049
Email: tcw@kca.org.uk

Information: This conference presents an action plan for agencies and professionals who work with drug users. Topics covered include: interventions in tackling hepatitis C, improving drug treatment outcomes and retention rates, inform effective commissioning of drug services to deal with hepatitis C and demonstrate the effectiveness for user involvement. Conference booking fee: Sterling £195

8 November 2006

Drug & Alcohol Professionals Conference 2006

Venue: Royal Institute of British Architects, 66 Portland Place, London
Organised by/contact: The Federation of Drug & Alcohol Professionals (FDAP) in association with Drink & Drugs News
www.fdap.org.uk

Information: FDAP's Annual Drug and Alcohol Professionals conference aims to help support the development of front line workers, managers and commissioners, and to give delegates the opportunity to have their say on important issues of the day. This year's event will include plenary presentations on the future of alcohol services, residential rehab and harm reduction, as well as the next steps on workforce development. Practically-focused workshops and seminars will cover a range of issues, such as: services for steroid users; meeting the needs of young people; working with clients with co-occurring gambling problems; brief therapies for alcohol problems; and, managing child protection issues. And delegates will have the chance to contribute to policy debates on: whether psychological therapies work with substance users; what role, if any, there should be for coercive treatment; and whether practitioners should have to be qualified to work in this field. Conference booking fee: FDAP Members–Sterling £110 Others–Sterling £140

16-17 November 2006

International Child Psychiatry Conference on the Treatment of Adolescent Addiction

Venue: The Davenport Hotel, Merrion Square, Dublin 2
Organised by/Contact: Drug Treatment Centre Board
Tel: + 353 (01) 6488600
www.addictionireland.ie/events

Information: The Drug Treatment Centre Board has designed a two-day Conference to take place in November 2006 with the main learning objective being to equip attendees with the basic skills to conduct assessments of complex adolescent addiction cases and to develop treatment plans to tackle the problems identified. The format of the Conference will involve a combination of lectures, case discussions, small-group work and workshops dealing with very specific area of treatment. Key team members from the DTCB Young Persons' Programme, including Dr Gerry McCarney and Dr Bobby Smyth, will deliver this conference, with special guest speaker Dr KAH Mirza. Cost is €295.00 per delegate, with a 10% reduction for groups of three or more from the same organisation. Places are limited.

The Drug Misuse Research Division (DMRD) of the Health Research Board is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug situation, its consequences and responses in Ireland. The DMRD maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. The division also manages the National Documentation Centre on Drug Use. The DMRD disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland*, and other publications. Through its activities, the DMRD aims to inform policy and practice in relation to drug use.

***Drugnet Ireland* mailing list**

If you wish to have your name included on the mailing list for future issues of Drugnet Ireland, please send your contact details to Charlene Lydon,
Drug Misuse Research Division,
Health Research Board,
Knockmaun House,
42–47 Lower Mount Street,
Dublin 2.
Tel: 01 676 1176 ext 127;
Email: dmrd@hrb.ie

Please indicate whether you would also like to be included on the mailing list for *Drugnet Europe* and *Drugs in focus*.

The documents referred to in this issue of *Drugnet Ireland* are available in the National Documentation Centre on Drug Use at the above address. Tel: 676 1176 ext 175; Email ndc@hrb.ie